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Contents

Federal Register

Vol. 81, No. 45

Tuesday, March 8, 2016

Agriculture Department
See Food and Nutrition Service
See Forest Service
See Rural Business-Cooperative Service
See Rural Housing Service

Centers for Disease Control and Prevention
NOTICES
Requests for Information:
NIOSH Center for Direct Reading and Sensor Technologies, Sensors for Emergency Response Activities; Extension of Comment Period, 12104

Centers for Medicare & Medicaid Services
RULES
Medicare Program:
Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Corrections, 12024–12030

Children and Families Administration
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Federal Tax Offset, Administrative Offset, and Passport Denial, 12104–12105
National Child Care Hotline and Website, 12105–12107

Coast Guard
RULES
Drawbridge Operations:
Mianus River, Greenwich, CT, 12007

Commerce Department
See First Responder Network Authority
See Industry and Security Bureau
See International Trade Administration
See National Oceanic and Atmospheric Administration
See National Telecommunications and Information Administration

Defense Department
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Fast Track Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery, 12080–12081

Education Department
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Private School Universe Survey June 2016 – May 2019, 12081
Applications for New Awards:
Education Research and Special Education Research Grant Programs, 12085–12092
Privacy Act; Systems of Records, 12081–12085

Energy Department
See Federal Energy Regulatory Commission

Environmental Protection Agency
RULES
Pesticide Tolerances:
Amitraz, Carfentrazone-ethyl, Ethephon, Malathion, Mancozeb, et al.; Correction, 12011
Fluopyram, 12015–12024
Zoxamide, 12011–12015
NOTICES
1-Bromopropane (1-BP); Availability of TSCA Work Plan Chemical Risk Assessment for Public Review and Comment, 12098–12099
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12097–12098
Meetings:
FIFRA Scientific Advisory Panel, 12099–12102

Export-Import Bank
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12102

Federal Aviation Administration
RULES
Amendment of Class D and Class E Airspace:
Salem, OR, 12002–12004
Establishment of Class E Airspace:
South Bend, WA, 12001–12002
PROPOSED RULES
Airworthiness Directives:
BAE Systems (Operations) Limited Airplanes, 12044–12047
The Boeing Company Airplanes, 12039–12044, 12047–12050
NOTICES
Meetings:
Aviation Rulemaking Advisory Committee, 12191–12192

Federal Communications Commission
PROPOSED RULES
Petition for Reconsideration of Action in a Rulemaking Proceeding, 12062
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12102–12103

Federal Energy Regulatory Commission
RULES
Annual Update to Fee Schedule for the Use of Government Lands by Hydropower Licensees; Corrections, 12006–12007
NOTICES
Applications:
PacifiCorp Energy; Authorization for Continued Project Operation, 12092–12093
Town of Pownal, 12093
Combined Filings, 12094–12097
Environmental Assessments; Availability, etc.:
Eastern Shore Natural Gas Co.; White Oak Mainline Expansion Project, 12095–12096
Freeport LNG Development, LP, et al.; Freeport LNG Capacity Uprate Project, 12092

Initial Market-Based Rate Filings Including Requests for Blanket Section 204 Authorizations:
Graphic Packaging International Inc., 12094
Staff Attendances, 12093–12094

Federal Motor Carrier Safety Administration
PROPOSED RULES
Carrier Safety Fitness Determination, 12062–12064

Federal Reserve System
NOTICES
Changes in Bank Control:
Acquisitions of Shares of a Bank or Bank Holding Company, 12103
Acquisitions of Shares of a Savings and Loan Holding Company, 12104
Formations of, Acquisitions by, and Mergers of Bank Holding Companies, 12103
Formations of, Acquisitions by, and Mergers of Savings and Loan Holding Companies, 12104
Proposals to Engage in or to Acquire Companies Engaged in Permissible Nonbanking Activities, 12103

First Responder Network Authority
NOTICES
Meetings:
National Telecommunications and Information Administration, 12069–12070

Fiscal Service
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12199–12201
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Request to Reissue U.S. Savings Bonds to a Personal Trust, 12200–12201

Fish and Wildlife Service
NOTICES
Endangered and Threatened Wildlife and Plants:
Draft Recovery Plan for Lilaeopsis schaffneriana ssp. recurva (Huachuca Water Umbel), 12115–12116
Environmental Assessments; Availability, etc.:
Draft Amended Oil and Gas Industry Conservation Plan for the American Burying Beetle in Oklahoma, 12113–12114
Mitigation Policy; Proposed Revisions, 12380–12403
Permits:
Endangered Species; Correction, 12116–12118

Food and Nutrition Service
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12065

Forest Service
NOTICES
Environmental Impact Statements; Availability, etc.:
Snow Basin Vegetation Management Project, Cancellation of Supplement; Wallowa-Whitman National Forest, OR, 12065–12066
Umatilla National Forest, North Fork John Day Ranger District; OR; Ten Cent Community Wildfire Protection Project, 12066–12067

Health and Human Services Department
See Centers for Disease Control and Prevention
See Centers for Medicare & Medicaid Services
See Children and Families Administration
See Health Resources and Services Administration
See National Institutes of Health
RULES
Patient Protection and Affordable Care Act:
Benefit and Payment Parameters, 12204–12352

Health Resources and Services Administration
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12107–12108
Low Income Levels Used for Various Health Professions and Nursing Programs Authorized in Titles III, VII, and VIII of the Public Health Service Act, 12108–12109

Historic Preservation, Advisory Council
NOTICES
Meetings:
Quarterly Business Meeting, 12112–12113

Homeland Security Department
See Coast Guard
See U.S. Customs and Border Protection

Housing and Urban Development Department
RULES
Streamlining Administrative Regulations for Public Housing, Housing Choice Voucher, Multifamily Housing, and Community Planning and Development Programs, 12354–12377
PROPOSED RULES
Housing Finance Agencies Risk-Sharing Program, 12051–12062

Industry and Security Bureau
RULES
Additions to the Entity List, 12004–12006

Interior Department
See Fish and Wildlife Service
See Land Management Bureau
See National Park Service
See Surface Mining Reclamation and Enforcement Office

International Trade Administration
NOTICES
Antidumping or Countervailing Duty Investigations, Orders, or Reviews:
Floor-Standing, Metal-Top Ironing Tables and Certain Parts Thereof from the People's Republic of China, 12070–12071
Investigations; Determinations, Modifications, and Rulings, etc.:
Certain Cold-Rolled Steel Flat Products from the Russian Federation, 12072–12075
Meetings:
Renewable Energy and Energy Efficiency Advisory Committee, 12071–12072

International Trade Commission
NOTICES
Appointment of Individuals to Serve as Members of the Performance Review Board, 12126

Justice Department
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Application for Cancellation of Removal (42A) for Certain Permanent Residents, etc., 12127–12128
Electronic Applications for the Attorney General's Honors Program and the Summer Law Intern Program, 12126–12127

Labor Department
See Workers Compensation Programs Office
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Benefit Rights and Experience Report, 12129
Statement of Expenditures and Financial Adjustments of Federal Funds for Unemployment Compensation for Federal Employees and Ex-Servicemembers, 12128

Land Management Bureau
NOTICES
Filings of Plats of Surveys:
California, 12118

Maritime Administration
NOTICES
Requests for Administrative Waivers of the Coastwise Trade Laws:
Vessel ALYKAT, 12195
Vessel BANDIDO, 12195–12196
Vessel BIG GAME, 12193–12194
Vessel CABERNET SKY, 12194–12195
Vessel HYPATIA, 12194
Vessel MISTY, 12192–12193
Vessel TENACIOUS, 12193

National Archives and Records Administration
RULES
Nixon Administration Presidential Historical Materials, 12007–12011

National Credit Union Administration
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Corporate Credit Unions, 12131

National Highway Traffic Safety Administration
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12196–12197

National Institutes of Health
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Survey to Assess the Feasibility of Establishing a Gynecologic Specimen Bank, 12111
Meetings:
Center for Scientific Review, 12110–12111
National Cancer Institute, 12111–12112
National Cancer Institute; Amendments, 12111
National Institute of Arthritis and Musculoskeletal and Skin Diseases, 12109–12110
National Institute on Minority Health and Health Disparities, 12109

National Oceanic and Atmospheric Administration
RULES
Fisheries of the Northeastern United States:
Summer Flounder Fishery; Quota Transfer, 12030–12031
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Coastal Ocean Program Grants Proposal Application Package, 12077–12078
Meetings:
Atlantic Shark Identification Workshops and Protected Species Safe Handling, Release, and Identification Workshops; Schedules, 12078–12080
Permits:
Endangered Species; File No. 19627, 12077
Marine Mammals; File No. 18978, 12075–12076
Requests for Information:
Identification of Nations Engaged in Illegal, Unreported, or Unregulated Fishing, Bycatch, or Shark Fishing, 12076–12077

National Park Service
NOTICES
Inventory Completions:
Chaco Culture National Historical Park, Nageezi, NM, 12122–12124
Native American Human Remains and Associated Funerary Objects in the Possession of the University of Denver Department of Anthropology and Museum of Anthropology, Denver, CO; Correction, 12120–12121
Tennessee Valley Authority, Knoxville, TN, 12121–12122
University of Denver Museum of Anthropology, Denver, CO, 12118–12120

National Science Foundation
NOTICES
Meetings; Sunshine Act, 12131

National Telecommunications and Information Administration

NOTICES
Meetings:
National Telecommunications and Information Administration, 12069–12070

Nuclear Regulatory Commission
NOTICES
Environmental Assessments; Availability, etc.:
Duke Energy Carolinas, LLC McGuire Nuclear Station, Units 1 and 2, 12132–12133
Environmental Impact Statements; Availability, etc.:
Strata Energy, Inc, Kendrick Expansion Area In Situ Uranium Recovery Project, 12143–12146
Exemption and Combined License Amendments:
Virgil C. Summer Nuclear Station, Units 2 and 3; South Carolina Electric and Gas; Reclassification of Tier 2 Information on Fire Area Figures, 12137–12138
Vogtle Electric Generating Station, Units 3 and 4; Southern Nuclear Operating Co., 12134–12136
Facility Operating and Combined Licenses:
Applications and Amendments Involving Proposed No Significant Hazards Considerations, etc., 12138–12143
Meetings:
ACRS Subcommittee on Metallurgy and Reactor Fuels, 12136–12137

Temporary Exemptions:
Power Resources, Inc., 12133–12134

Personnel Management Office
PROPOSED RULES
Federal Employees' Group Life Insurance Program:
Filing Deadlines for Court Review of Administrative Final Decisions; Withdrawal, 12032
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Annuitant's Report of Earned Income, 12147
Initial Certification of Full-Time School Attendance, 12147–12148
Reinstatement of Disability Annuity Previously Terminated Because of Restoration to Earning Capacity, 12146–12147

Postal Regulatory Commission
NOTICES
New Postal Products, 12148–12149

Postal Service
NOTICES
Product Changes:
Priority Mail and First-Class Package Service Negotiated Service Agreement, 12149

Rural Business-Cooperative Service
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12067–12068

Rural Housing Service
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12068–12069

Securities and Exchange Commission
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12159–12160, 12165
Applications:
Apollo Investment Corporation, et al., 12165–12174
Ares Management LLC, 12178–12184
Crescent Capital BDC Inc., et al., 12155–12159
Joint Industry Plan:
Tick Size Pilot Program to Add National Stock Exchange, Inc. as a Participant, 12162–12163
Self-Regulatory Organizations; Proposed Rule Changes:
Bats BZX Exchange, Inc., 12175–12176
NASDAQ OMX BX, Inc., 12184–12187
NASDAQ PHLX, LLC, 12160–12162
NASDAQ Stock Market, LLC, 12151–12153
New York Stock Exchange, LLC, 12177–12178
NYSE Arca, Inc., 12154–12155, 12163–12165, 12188–12190
NYSE Arca, Inc.; Correction, 12174–12175
NYSE MKT, LLC, 12150–12151, 12187–12188

Small Business Administration
NOTICES
Disaster Declarations:
Tennessee, 12190

State Department
PROPOSED RULES
Visas:
Documentation of Nonimmigrants under the Immigration and Nationality Act, 12050–12051
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
INTERNational Connections, 12190–12191

Surface Mining Reclamation and Enforcement Office
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12124–12126

Trade Representative, Office of United States
NOTICES
Reallocation of Unused Fiscal Year 2016 Tariff-Rate Quota Volume for Raw Cane Sugar, 12191

Transportation Department
See Federal Aviation Administration
See Federal Motor Carrier Safety Administration
See Maritime Administration
See National Highway Traffic Safety Administration
NOTICES
Federal Motor Vehicle Theft Prevention Standard Exemption Petitions:
American Honda Motor Co., Inc., 12197–12199

Treasury Department
See Fiscal Service

U.S. Customs and Border Protection
PROPOSED RULES
Waiver of Passport and Visa Requirements Due to an Unforeseen Emergency, 12032–12038

Veterans Affairs Department
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals:
Report of Subcontracts to Small and Veteran-Owned Business, 12201–12202
Meetings:
Commission on Care, 12201

Workers Compensation Programs Office
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 12129–12130

Separate Parts In This Issue

Part II
Health and Human Services Department, 12204–12352

Part III
Housing and Urban Development Department, 12354–12377

Part IV
Interior Department, Fish and Wildlife Service, 12380–12403

Reader Aids

Consult the Reader Aids section at the end of this issue for phone numbers, online resources, finding aids, and notice of recently enacted public laws.

To subscribe to the Federal Register Table of Contents LISTSERV electronic mailing list, go to http://listserv.access.gpo.gov and select Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings); then follow the instructions.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

5 CFR

Proposed Rules:

870.....12032

8 CFR

Proposed Rules:

212.....12032

14 CFR

71 (2 documents) 12001, 12002

Proposed Rules:

39 (4 documents) 12039, 12041, 12044, 12047

15 CFR

744.....12004

18 CFR

11.....12006

22 CFR

Proposed Rules:

41.....12050

24 CFR

5.....12354
880.....12354
884.....12354
886.....12354
891.....12354
903.....12354
960.....12354
966.....12354
982.....12354
983.....12354
990.....12354

Proposed Rules:

266.....12051

33 CFR

117.....12007

36 CFR

1275.....12007

40 CFR

180 (3 documents) 12011, 12015

42 CFR

405.....12024
410.....12024
411.....12024
414.....12024
425.....12024
495.....12024

45 CFR

144.....12204
147.....12204
153.....12204
154.....12204
155.....12204
156.....12204
158.....12204

47 CFR

Proposed Rules:

64.....12062

49 CFR

Proposed Rules:

350.....12062
365.....12062
385.....12062
386.....12062
387.....12062
395.....12062

50 CFR

648.....12030

Rules and Regulations

Federal Register
Vol. 81, No. 45
Tuesday, March 8, 2016

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2015–3771; Airspace Docket No. 15–ANM–28]

Establishment of Class E Airspace, South Bend, WA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action establishes Class E airspace at Willapa Harbor Heliport, South Bend, WA, to accommodate new standard instrument approach and departure procedures developed at the heliport. Controlled airspace is necessary for the safety and management of Instrument Flight Rules (IFR) operations at the heliport.

DATES: Effective 0901 UTC, May 26, 2016. The Director of the Federal Register approves this incorporation by reference action under Title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

ADDRESSES: FAA Order 7400.9Z, Airspace Designations and Reporting Points, and subsequent amendments can be viewed online at *http://www.faa.gov/air_traffic/publications/.* For further information, you can contact the Airspace Policy Group, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone: 202–267–8783. The Order is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of FAA Order 7400.9Z at NARA, call 202–741–6030, or go to *http://www.archives.gov/federal_register/code_of_federal-regulations/ibr_locations.html.*

FAA Order 7400.9, Airspace Designations and Reporting Points, is published yearly and effective on September 15.

FOR FURTHER INFORMATION CONTACT: Tom Clark, Federal Aviation Administration, Operations Support Group, Western Service Center, 1601 Lind Avenue SW., Renton, WA 98057; telephone (425) 203–4511.

SUPPLEMENTARY INFORMATION:

Authority for This Rulemaking

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part, A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes Class E airspace at Willapa Harbor Heliport, South Bend, WA.

History

On November 24, 2015, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to establish Class E airspace extending upward from 700 feet above the surface, at Willapa Harbor Heliport, South Bend, WA, (80 FR 73152). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received.

Availability and Summary of Documents for Incorporation by Reference

This document amends FAA Order 7400.9Z, Airspace Designations and Reporting Points, dated August 6, 2015, and effective September 15, 2015. FAA Order 7400.9Z is publicly available as listed in the **ADDRESSES** section of this document. FAA Order 7400.9Z lists Class A, B, C, D, and E airspace areas, air traffic service routes, and reporting points.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 establishes Class E airspace extending upward from 700 feet above the surface at Willapa Harbor Heliport, South Bend, WA. Establishment of a GPS approach and departure procedure has made this action necessary for the safety and management of IFR operations at the heliport. Class E airspace is established within a 1.8-mile radius of the Willapa Harbor Heliport, with a segment extending from the 1.8-mile radius to 5.5 miles northwest of the heliport.

Regulatory Notices and Analyses

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore: (1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1F, ''Environmental Impacts: Policies and Procedures,'' paragraph 5–6.5a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of FAA Order 7400.9Z, Airspace Designations and Reporting Points, dated August 6, 2015, and effective September 15, 2015, is amended as follows:

Paragraph 5000 Class D Airspace.

* * * * *

ANM WA E5 Willapa Harbor Heliport, South Bend, WA [New]

Willapa Harbor Heliport, WA
(Lat. 46°39′47″ N., long. 123°48′44″ W.)

That airspace extending upward from 700 feet above the surface within a 1.8-mile radius of Willapa Harbor Heliport, and that airspace bounded by a line beginning at a point where the Willapa Harbor 278° bearing intersects the Willapa Harbor 1.8-mile radius, thence northwest to lat. 46°42′26″ N., long. 123°55′39″ W.; to lat. 46°45′28″ N., long. 123°52′46″ W.; to lat. 46°43′55″ N., long. 123°48′46″ W.; to lat. 46°41′18″ N., long. 123°46′14″ W.; to a point where the Willapa Harbor 98° bearing intersects the Willapa Harbor 1.8-mile radius, thence clockwise along the 1.8-mile radius to the point of beginning.

Issued in Seattle, Washington, on February 26, 2016.

Christopher Ramirez,

Acting Manager, Operations Support Group, Western Service Center.

[FR Doc. 2016–05059 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2015–3751; Airspace Docket No. 15–ANM–20]

Amendment of Class D and Class E Airspace; Salem, OR

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action modifies Class D airspace, Class E surface area airspace, and Class E airspace extending upward from 700 feet above the surface at McNary Field, Salem, OR. After further review, the FAA found some airspace unnecessary for Standard Instrument Approach Procedures during Instrument Flight Rules (IFR) operations at the airport. This action brings the controlled airspace into compliance with current FAA requirements, and adds to the safety and management of IFR operations at the airport.

DATES: Effective 0901 UTC, May 26, 2016. The Director of the Federal Register approves this incorporation by reference action under Title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

ADDRESSES: FAA Order 7400.9Z, Airspace Designations and Reporting Points, and subsequent amendments can be viewed online at *http://www.faa.gov/air_traffic/publications/.* For further information, you can contact the Airspace Policy Group, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone: 202–267–8783. The Order is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of FAA Order 7400.9Z at NARA, call 202–741–6030, or go to *http://www.archives.gov/federal_register/code_of_federal-regulations/ibr_locations.html.*

FAA Order 7400.9, Airspace Designations and Reporting Points, is published yearly and effective on September 15.

FOR FURTHER INFORMATION CONTACT: Steve Haga, Federal Aviation Administration, Operations Support Group, Western Service Center, 1601 Lind Avenue SW., Renton, WA 98057; telephone (425) 203–4563.

SUPPLEMENTARY INFORMATION:

Authority for This Rulemaking

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends Class D and Class E airspace at McNary Field, Salem, OR.

History

On September 21, 2015, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to modify Class D airspace, Class E surface area airspace, Class E airspace extending upward from 700 feet above the surface at McNary Field, Salem, OR, (80 FR 56935). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. A total of 71 commenters responded to the NPRM. All comments received were considered before making a determination on this final rule.

Discussion of Comments

Of the 71 responses received, 19 concerned the potential economic impact to Christmas tree farms in the area. The FAA concurs that approximately two thirds of the Christmas tree farming acreage could be adversely affected. To mitigate the concerns for the agricultural areas, the FAA is creating shelves in the Class D, where feasible, between 4 and 5 miles southeast and southwest of the airport.

Many commenters made reference to the current airspace configuration. As the comments do not pertain to this proposal, no changes were required nor made. Twenty-four commenters requested the airspace to be changed to a configuration that existed prior to Aug 20, 2015. The FAA does not agree; the airspace that existed prior to Aug 20, 2015 did not protect the Instrument Flight Rule arrivals and departures or account for rising terrain.

Many commenters referenced the lack of adherence to airspace design criteria and Safety Risk Management directives during the previous airspace development process. The FAA does not concur. A review of the design process and the results was completed for both the current and previous proposals. The FAA found that all criteria contained in FAA Order JO 7400.2, Procedures for Handling Airspace Matters; FAA Order JO 8000.369, Safety Management System and the Administrative Procedures Act (5 U.S.C. 501 *et seq.*) were followed.

Nineteen commenters referenced a lack of public input. The FAA conducted a review of the process and found that all public coordination was completed consistent with the process outlined in JO 7400.2.

Three commenters were concerned that users would not be aware of airspace changes. They recommended that future airspace changes occur congruently with VFR Sectional chart publication and that a Notice to Airman

(NOTAM) be used to identify pending changes. The FAA does not concur with publishing airspace changes congruent with the charting cycles; this could unnecessarily delay airspace changes six months to a year. Changes that become effective outside of the chart publication cycles are reflected in the Airport/Facilities Directory (A/FD), in the Aeronautical Chart Bulletin section. Pilots are required to consult the AF/D, prior to flying in a specific area, for information related to airspace changes that are pending. This publication is reviewed to ensure the potential airspace changes are published and accurate. For this proposal the FAA agrees to coordinate congruent effective and charting dates. Additionally, the FAA has modified its policies to allow a facility to post a Pointer NOTAM indicating the location of additional information for expanding airspace, to advise the aviation community of an airspace increase or altitude change that occurs outside of a sectional chart cycle.

Several commenters stated that Salem air traffic control tower was not aware of the changes. The FAA does not agree with these comments, as the facility was directly involved in and concurred with, the previous and current proposals.

Changes From the NPRM

The description of the Class D airspace area has been modified from that proposed in the NPRM. In light of public input, the FAA reevaluated the Class D design for McNary Field and incorporated shelves to facilitate access, into and out of the impacted Christmas Tree Farms, by commercial operators.

Class D and Class E airspace designations are published in paragraph 5000, 6002, and 6005, respectively, of FAA Order 7400.9Z, dated August 6, 2015, and effective September 15, 2015, which is incorporated by reference in 14 CFR part 71.1. The Class E airspace designation listed in this document will be published subsequently in the Order.

Availability and Summary of Documents for Incorporation by Reference

This document amends FAA Order 7400.9Z, Airspace Designations and Reporting Points, dated August 6, 2015, and effective September 15, 2015. FAA Order 7400.9Z is publicly available as listed in the **ADDRESSES** section of this document. FAA Order 7400.9Z lists Class A, B, C, D, and E airspace areas, air traffic service routes, and reporting points.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 modifies Class D airspace, Class E surface area airspace, and Class E airspace extending upward from 700 feet above the surface at McNary Field, Salem, OR. After further review, the FAA found some airspace unnecessary when implementing Standard Instrument Approach Procedures for Instrument Flight Rules (IFR) operations at the airport. Class D airspace is extended upward from the surface to and including 2,700 feet within a 4-mile radius of McNary Field Airport, extending to 5 miles from the east clockwise to the north, excluding segments below 1,500 feet beyond 4 miles east and southwest of the airport. Class E surface area airspace extends upward from the surface within a 4-mile radius of McNary Field Airport, extending to 5 miles from the east clockwise to the north of the airport. Class E airspace extending upward from 700 feet above the surface is modified to within a 6.2-mile radius south to the northwest of McNary Field, with segments extending to 6.7 miles to the northeast, and 8.2 miles to the southeast of the airport.

Regulatory Notices and Analyses

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore: (1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1F, ''Environmental Impacts: Policies and Procedures,'' paragraph 5–6.5a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of FAA Order 7400.9Z, Airspace Designations and Reporting Points, dated August 6, 2015, and effective September 15, 2015, is amended as follows:

Paragraph 5000 Class D Airspace.

* * * * *

ANM OR D Salem, OR [Modified]

Salem, McNary Field, OR
(Lat. 44°54′34″ N., long. 123°00′09″ W.)

That airspace extending upward from the surface to and including 2,700 feet within a 4-mile radius of McNary Field from the 330° bearing from the airport clockwise to the 74° bearing, extending to a 5-mile radius from the 74° bearing clockwise to the 330° bearing from the airport, excluding that airspace below 1,500 feet beyond 4 miles from the airport from the 74° bearing clockwise to the 133° bearing, and that airspace below 1,500 feet beyond 4 miles from the airport from the 164° bearing clockwise to the 254° bearing from the airport. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6002 Class E Airspace Designated as Surface Areas.

* * * * *

ANM OR E2 Salem, OR [Modified]

Salem, McNary Field, OR
(Lat. 44°54′34″ N., long. 123°00′09″ W.)

That airspace extending upward from the surface within a 4-mile radius of McNary Field from the 330° bearing from the airport clockwise to the 074° bearing, and that airspace within a 5-mile radius of McNary Field from the 074° bearing from the airport clockwise to the 330° bearing.

Paragraph 6005 Class E Airspace Areas Extending Upward From 700 Feet or More Above the Surface of the Earth.

* * * * *

ANM OR E5 Salem, OR [Modified]

Salem, McNary Field, OR
(Lat. 44°54′34″ N., long. 123°00′09″ W.)

That airspace extending upward from 700 feet above the surface within a 6.2-mile radius of McNary Field from the 164° bearing from the airport clockwise to the 315° bearing, and that airspace within a 6.7-mile radius of McNary Field from the 315° bearing from the airport clockwise to the 074° bearing, and that airspace within a 8.2-mile radius of McNary Field from the 074° bearing from the airport clockwise to the 164° bearing of the airport.

Issued in Seattle, Washington, on February 26, 2016.

Tracey Johnson,

Manager, Operations Support Group, Western Service Center.

[FR Doc. 2016–05060 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

15 CFR Part 744

[Docket No. 160106014–6014–01]

RIN 0694–AG82

Additions to the Entity List

AGENCY: Bureau of Industry and Security, Commerce.

ACTION: Final rule.

SUMMARY: This rule amends the Export Administration Regulations (EAR) by adding four entities to the Entity List. The U.S. Government has determined that the four entities are acting contrary to the national security or foreign policy interests of the United States. The four entities will be listed on the Entity List under the destinations of People's Republic of China (China) and Iran.

DATES: This rule is effective March 8, 2016.

FOR FURTHER INFORMATION CONTACT: Chair, End-User Review Committee, Office of the Assistant Secretary, Export Administration, Bureau of Industry and Security, Department of Commerce, Phone: (202) 482–5991, Fax: (202) 482–3911, Email: *ERC@bis.doc.gov.*

SUPPLEMENTARY INFORMATION:

Background

The Entity List (Supplement No. 4 to Part 744) identifies entities and other persons reasonably believed to be involved, or to pose a significant risk of being or becoming involved, in activities contrary to the national security or foreign policy interests of the United States. The EAR imposes additional licensing requirements on, and limits the availability of most license exceptions for, exports, reexports, and transfers (in-country) to those listed. The ''license review policy'' for each listed entity or other person is identified in the License Review Policy column on the Entity List and the impact on the availability of license exceptions is described in the **Federal Register** notice adding entities or other persons to the Entity List. BIS places entities and other persons on the Entity List pursuant to sections of part 744 (Control Policy: End-User and End-Use Based) and part 746 (Embargoes and Other Special Controls) of the EAR.

The ERC, composed of representatives of the Departments of Commerce (Chair), State, Defense, Energy, and, where appropriate, the Treasury, determines all additions to, removals from, and other modifications to the Entity List. The ERC makes decisions to add an entry to the Entity List by majority vote and decisions to remove or modify an entry by unanimous vote.

ERC Entity List Decisions

Additions to the Entity List

This rule implements the decision of the ERC to add four entities—three in China and one in Iran—to the Entity List under the authority of § 744.11 (License requirements that apply to entities acting contrary to the national security or foreign policy interests of the United States) of the EAR.

The ERC reviewed § 744.11(b) (Criteria for revising the Entity List) in making the determination to list these four entities. Under that paragraph, entities and other persons for which there is reasonable cause to believe, based on specific and articulable facts, have been involved, are involved, or pose a significant risk of being or becoming involved in, activities that are contrary to the national security or foreign policy interests of the United States, and those acting on behalf of such persons, may be added to the Entity List. Paragraphs (b)(1) through (5) of § 744.11 set out an illustrative list of activities that could be contrary to the national security or foreign policy interests of the United States.

Pursuant to § 744.11 of the EAR, the ERC determined that Zhongxing Telecommunications Equipment Corporation (''ZTE Corporation''), located at ZTE Plaza, Keji Road South, Hi-Tech Industrial Park, Nenshan District, Shenzhen, China, be added to the Entity List under the destination of China for actions contrary to the national security and foreign policy interests of the United States. Specifically, the ZTE Corporation document ''Report Regarding Comprehensive Reorganization and Standardization of the Company Export Control Related Matters'' (available at *http://www.bis.doc.gov*) indicates that ZTE Corporation has reexported controlled items to sanctioned countries contrary to United States law. The ZTE Corporation document ''Proposal for Import and Export Control Risk Avoidance'' (available at *http://www.bis.doc.gov*) describes how ZTE Corporation also planned and organized a scheme to establish, control, and use a series of ''detached'' (*i.e.,* shell) companies to illicitly reexport controlled items to Iran in violation of U.S. export control laws.

Pursuant to § 744.11 of the EAR, the ERC determined that three entities located in China and one in Iran should be added to the Entity List for actions contrary to the national security or foreign policy interests of the United States. Specifically, the following three entities (in addition to ZTE Corporation) were identified in the scheme developed by ZTE Corporation to reexport controlled items to Iran contrary to United States law, as detailed in the ZTE Corporation document ''Proposal for Import and Export Control Risk Avoidance,'' referenced above and available on the BIS Web site:

(a) ZTE Kangxun Telecommunications Ltd. is named in the ZTE Corporation document ''Proposal for Import and Export Control Risk Avoidance.'' This entity was designated by ZTE Corporation to purchase controlled items and provide them to a Chinese intermediary trading company for reexport to Iran.

(b) Beijing 8-Star, identified as ''8S'' is described in the ZTE Corporation document ''Proposal for Import and Export Control Risk Avoidance.'' This entity was designated by ZTE Corporation to sign contracts with Iranian clients, make purchases of controlled items, and reexport the items from China to Iran.

(c) ZTE Parsian is identified as ''ZTE YL'' in the ZTE Corporation document ''Proposal for Import and Export Control Risk Avoidance.'' This entity was designated by ZTE Corporation to facilitate the illicit reexport scheme by providing contracted engineering services to ZTE client(s) in Iran receiving the controlled items.

Pursuant to § 744.11(b)(5) of the EAR, the ERC determined that the conduct of these four entities raises sufficient concern that the prior review of exports, reexports, and transfers (in-country) of items subject to the EAR involving these

entities, and the possible imposition of license conditions or license denials on shipments to the entities, will enhance BIS's ability to prevent violations of the EAR.

For the four entities this rule adds to the Entity List on the basis of § 744.11, the ERC specified a license requirement for all items subject to the EAR and a license review policy of presumption of denial. The license requirements apply to any transaction in which items subject to the EAR are proposed for export, reexport, or transfer (in-country) to any of the four listed entities or any other transaction in which such entities act as purchaser, intermediate consignee, ultimate consignee, or end user of items subject to the EAR. In addition, no license exceptions are available for exports, reexports, or transfers (in-country) of items subject to the EAR to the entities being added to the Entity List in this rule.

This final rule adds the following four entities to the Entity List:

China

(1) *Beijing 8-Star International Co.,* Unit 601, 6th Floor, Tower 1, Prosper Center, No. 5, Guanghua Road, Chaoyang District, Beijing, China;

(2) *Zhongxing Telecommunications Equipment (ZTE) Corporation,* ZTE Plaza, Keji Road South, Hi-Tech Industrial Park, Nanshan District, Shenzen, China; *and*

(3) *ZTE Kangxun Telecommunications Ltd.,* 2/3 Floor, Suite A, Zte Communication Mansion Keji (S) Road, Hi-New Shenzhen, 518057 China.

Iran

(1) *ZTE Parsian,* No. 100, Africa Ave., Mirdamad Entersection, Tehran, Iran.

Savings Clause

Shipments of items removed from eligibility for a License Exception or export or reexport without a license (NLR) as a result of this regulatory action that were *en route* aboard a carrier to a port of export or reexport, on March 8, 2016, pursuant to actual orders for export or reexport to a foreign destination, may proceed to that destination under the previous eligibility for a License Exception or export or reexport without a license (NLR).

Export Administration Act

Although the Export Administration Act expired on August 20, 2001, the President, through Executive Order 13222 of August 17, 2001, 3 CFR, 2001 Comp., p. 783 (2002), as amended by Executive Order 13637 of March 8, 2013, 78 FR 16129 (March 13, 2013) and as extended by the Notice of August 7, 2015, 80 FR 48233 (August 11, 2015), has continued the Export Administration Regulations in effect under the International Emergency Economic Powers Act. BIS continues to carry out the provisions of the Export Administration Act, as appropriate and to the extent permitted by law, pursuant to Executive Order 13222, as amended by Executive Order 13637.

Rulemaking Requirements

1. Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been determined to be not significant for purposes of Executive Order 12866.

2. Notwithstanding any other provision of law, no person is required to respond to nor be subject to a penalty for failure to comply with a collection of information, subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) (PRA), unless that collection of information displays a currently valid Office of Management and Budget (OMB) Control Number. This regulation involves collections previously approved by OMB under control number 0694–0088, Simplified Network Application Processing System, which includes, among other things, license applications and carries a burden estimate of 43.8 minutes for a manual or electronic submission. Total burden hours associated with the PRA and OMB control number 0694–0088 are not expected to increase as a result of this rule. You may send comments regarding the collection of information associated with this rule, including suggestions for reducing the burden, to Jasmeet K. Seehra, Office of Management and Budget (OMB), by email to *Jasmeet_K._Seehra@omb.eop.gov,* or by fax to (202) 395–7285.

3. This rule does not contain policies with Federalism implications as that term is defined in Executive Order 13132.

4. For the four entities added to the Entity List in this final rule, the provisions of the Administrative Procedure Act (5 U.S.C. 553) requiring notice of proposed rulemaking, the opportunity for public comment, and a delay in effective date are inapplicable because this regulation involves a military or foreign affairs function of the United States. (*See* 5 U.S.C. 553(a)(1)). BIS implements this rule to protect U.S. national security or foreign policy interests by preventing items from being exported, reexported, or transferred (in-country) to the entities being added to the Entity List. If this rule were delayed to allow for notice and comment and a delay in effective date, then entities being added to the Entity List by this action would continue to be able to receive items without a license and to conduct activities contrary to the national security or foreign policy interests of the United States. In addition, because these parties may receive notice of the U.S. Government's intention to place this entity on the Entity List if a proposed rule is published, doing so would create an incentive for these entities to either accelerate receiving items subject to the EAR to conduct activities that are contrary to the national security or foreign policy interests of the United States, or to take steps to set up additional aliases, change addresses, and other measures to try to limit the impact of the listing on the Entity List once a final rule was published. Further, no other law requires that a notice of proposed rulemaking and an opportunity for public comment be given for this rule. Because a notice of proposed rulemaking and an opportunity for public comment are not required to be given for this rule by 5 U.S.C. 553, or by any other law, the analytical requirements of the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.,* are not applicable. Accordingly, no regulatory flexibility analysis is required and none has been prepared.

List of Subject in 15 CFR Part 744

Exports, Reporting and recordkeeping requirements, Terrorism.

Accordingly, part 744 of the Export Administration Regulations (15 CFR parts 730–774) is amended as follows:

PART 744—[AMENDED]

■ 1. The authority citation for 15 CFR part 744 continues to read as follows:

Authority: 50 U.S.C. 4601 *et seq.;* 50 U.S.C. 1701 *et seq.;* 22 U.S.C. 3201 *et seq.;* 42 U.S.C. 2139a; 22 U.S.C. 7201 *et seq.;* 22 U.S.C. 7210; E.O. 12058, 43 FR 20947, 3 CFR, 1978 Comp., p. 179; E.O. 12851, 58 FR 33181, 3 CFR, 1993 Comp., p. 608; E.O. 12938, 59 FR 59099, 3 CFR, 1994 Comp., p. 950; E.O. 12947, 60 FR 5079, 3 CFR, 1995 Comp., p. 356; E.O. 13026, 61 FR 58767, 3 CFR, 1996

Comp., p. 228; E.O. 13099, 63 FR 45167, 3 CFR, 1998 Comp., p. 208; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783; E.O. 13224, 66 FR 49079, 3 CFR, 2001 Comp., p. 786; Notice of August 7, 2015, 80 FR 48233 (August 11, 2015); Notice of September 18, 2015, 80 FR 57281 (September 22, 2015); Notice of November 12, 2015, 80 FR 70667 (November 13, 2015); Notice of January 20, 2016, 81 FR 3937 (January 22, 2016).

■ 2. Supplement No. 4 to part 744 is amended:

■ a. By adding under China, in alphabetical order, three Chinese entities; and

■ b. By adding under Iran, in alphabetical order, one Iranian entity.

The additions read as follows:

Supplement No. 4 to Part 744—Entity List

* * * * *

Country	Entity	License requirement	License review policy	**Federal Register** citation
*	* * *	* *	* *	*
CHINA, PEOPLE'S REPUBLIC OF.	*	* *	*	*
	Beijing 8 Star International Co., Unit 601, 6th Floor, Tower 1, Prosper Center, No. 5, Guanghua Road, Chaoyang District, Beijing, China	For all items subject to the EAR. (See § 744.11 of the EAR)	Presumption of denial	81 FR [INSERT FR PAGE NUMBER], 3/8/16.
	*	* *	*	*
	Zhongxing Telecommunications Equipment (ZTE) Corporation, ZTE Plaza, Keji Road South, Hi-Tech Industrial Park, Nanshan District, Shenzen, China	For all items subject to the EAR. (See § 744.11 of the EAR)	Presumption of denial	81 FR [INSERT FR PAGE NUMBER], 3/8/16.
	ZTE Kangxun Telecommunications Ltd., 2/3 Floor, Suite A, Zte Communication Mansion Keji (S) Road, Hi-New Shenzhen, 518057 China	For all items subject to the EAR. (See § 744.11 of the EAR)	Presumption of denial	81 FR [INSERT FR PAGE NUMBER], 3/8/16.
	*	* *	*	*
*	* * *	* *	* *	*
IRAN	*	* *	*	*
	ZTE Parsian, No. 100, Africa Ave., Mirdamad Entersection, Tehran, Iran	For all items subject to the EAR. (See § 744.11 of the EAR)	Presumption of denial	81 FR [INSERT FR PAGE NUMBER], 3/8/16.
*	* * *	* *	* *	*

Dated: March 3, 2016.

Kevin J. Wolf,

Assistant Secretary for Export Administration.

[FR Doc. 2016–05104 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–33–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

18 CFR Part 11

[Docket No. RM11–6–000]

Annual Update to Fee Schedule for the Use of Government Lands by Hydropower Licensees; Correction

AGENCY: Federal Energy Regulatory Commission.

ACTION: Correcting amendment.

SUMMARY: This document contains corrections to the final rule (RM11–6–000) which published in the **Federal Register** on Wednesday, February 24, 2016 (81 FR 9090). The Final Rule provided the annual update to the fee schedule in Appendix A to Part 11, which lists per-acre rental fees by county (or other geographic area) for use of government lands by hydropower licensees and updated Appendix A to Part 11 with the fee schedule of per-acre rental fees by county (or other geographic area) from October 1, 2015, through September 30, 2016 (Fiscal Year 2016).

DATES: Effective March 8, 2016, and is applicable beginning February 24, 2016.

FOR FURTHER INFORMATION CONTACT: Norman Richardson, Financial Management Division, Office of the Executive Director, Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426, (202) 502–6219, *Norman.Richardson@ferc.gov.*

SUPPLEMENTARY INFORMATION: On February 18, 2016, the Commission issued an *Annual Update to Fee Schedule for the Use of Government Lands for Hydropower Licensees* in the above-captioned proceeding. Pursuant to *Annual Charges for the Use of Government Lands,* Order No. 774, 78 FR 5256 (January 25, 2013), FERC Stats. & Regs. ¶ 31,341 (2013) this document corrects the per-acre values for the State of Nevada, as reflected in the caption below.

List of Subjects in 18 CFR Part 11

Public lands.

Accordingly, 18 CFR part 11 is corrected by making the following correcting amendment:

PART 11—[AMENDED]

■ 1. The authority citation for part 11 continues to read as follows:

Authority: 16 U.S.C. 792–828c; 42 U.S.C. 7101–7352.

■ 2. Appendix A to Part 11 is amended by revising the entries under ''Nevada'' to read as follows:

Appendix A to Part 11—Fee Schedule for FY 2016

State	County	Fee/acre/yr
*	* * *	*
Nevada	Carson City	$51.65
	Churchill	18.72
	Clark	43.21
	Douglas	22.21
	Elko	3.81
	Esmeralda	13.79

State	County	Fee/acre/yr
	Eureka	4.98
	Humboldt	7.63
	Lander	5.72
	Lincoln	22.38
	Lyon	16.89
	Mineral	3.30
	Nye	16.47
	Pershing	7.18
	Storey	295.52
	Washoe	6.27
	White Pine	6.29
*	* * * *	*

Issued: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05100 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2016–0147]

Drawbridge Operation Regulation; Mianus River, Greenwich, CT

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulation.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the Metro-North Bridge across the Mianus River, mile 1.0, at Greenwich, Connecticut. This deviation is necessary to allow the bridge owner to perform superstructure repairs and timber ties replacement.

DATES: This deviation is effective from 8 a.m. on March 21, 2016 to 8 a.m. on June 27, 2016.

ADDRESSES: The docket for this deviation, [USCG–2016–0147] is available at *http://www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH''. Click on Open Docket Folder on the line associated with this deviation.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Judy Leung-Yee, Project Officer, First Coast Guard District, telephone (212) 514–4330, email *judy.k.leung-yee@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Metro-North Bridge, mile 1.0, across the Mianus River, has a vertical clearance in the closed position of 20 feet at mean high water and 27 feet at mean low water. The existing bridge operating regulations are found at 33 CFR 117.209.

The waterway is transited by seasonal recreational traffic.

Connecticut DOT requested a temporary deviation from the normal operating schedule to perform superstructure repairs and timber ties replacement at the bridge.

Under this temporary deviation, the Metro-North Bridge will operate according to the schedule below:

a. From March 21, 2016 8 a.m. to March 25, 2016 4 a.m. the bridge will not open to marine traffic.

b. From March 25, 2016 4 a.m. to March 28, 2016 8 a.m. the bridge will open fully on signal upon 24 hour advance notice.

c. From March 28, 2016 8 a.m. to April 01, 2016 4 a.m. the bridge will not open to marine traffic.

d. From April 01, 2016 4 a.m. to April 04, 2016 8 a.m. the bridge will open fully on signal upon 24 hour advance notice.

e. From April 04, 2016 8 a.m. to April 08, 2016 4 a.m. the bridge will not open to marine traffic.

f. From April 08, 2016 4 a.m. to April 11, 2016 8 a.m. the bridge will open fully on signal upon 24 hour advance notice.

g. From April 11, 2016 8 a.m. to April 15, 2016 4 a.m. the bridge will not open to marine traffic.

h. From April 15, 2016 4 a.m. to April 18, 2016 8 a.m. the bridge will open fully on signal upon 24 hour advance notice.

(Rain dates/Back up dates)

a. From June 13, 2016 8 a.m. to June 17, 2016 4 a.m. the bridge will not open to marine traffic.

b. From June 17, 2016 4 a.m. to June 20, 2016 8 a.m. the bridge will open fully on signal upon 24 hour advance notice.

c. From June 20, 2016 8 a.m. to June 24, 2016 4 a.m. the bridge will not open to marine traffic.

d. From June 24, 2016 4 a.m. to June 27, 2016 8 a.m. the bridge will open fully on signal upon 24 hour advance notice.

Vessels able to pass under the bridge in the closed position may do so at anytime. The bridge will not be able to open for emergencies and there is no immediate alternate route for vessels to pass.

The Coast Guard will inform the users of the waterways through our Local Notice and Broadcast to Mariners of the change in operating schedule for the bridge so that vessel operations can arrange their transits to minimize any impact caused by the temporary deviation.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: March 2, 2016.

C.J. Bisignano,

Supervisory Bridge Management Specialist, First Coast Guard District.

[FR Doc. 2016–05076 Filed 3–7–16; 8:45 am]

BILLING CODE 9110–04–P

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

36 CFR Part 1275

[FDMS No. NARA–16–0004; NARA–2016–019]

RIN 3095–AB86

Nixon Administration Presidential Historical Materials

AGENCY: National Archives and Records Administration (NARA).

ACTION: Direct final rule.

SUMMARY: NARA is amending this regulation to update provisions in accord with recent developments, including completed processing of the five chronological tape segments, as required by section 6 of the *Kutler* settlement agreement. The changes are primarily administrative and focus on changes to certain access and notice provisions currently in the regulations, as well as minor word and sentence changes in line with Plain Language Act provisions. Because NARA has completed the requirements of the *Kutler* Settlement agreement, we are removing it as an appendix to this part.

DATES: This rule is effective April 7, 2016, without further action, unless NARA receives adverse comments by March 28, 2016. If NARA receives an adverse comment, it will publish a timely withdrawal of the rule in the **Federal Register**.

ADDRESSES: You may submit comments on this rule, identified by RIN 3095–AB86, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Email: Regulation_comments@nara.gov.* Include RIN 3095–AB86 in the subject line of the message.
- *Mail (for paper, disk, or CD–ROM submissions):* Send comments to: Regulations Comments Desk (External Policy Program, Strategy & Performance Division (SP)); Suite 4100; National Archives and Records Administration; 8601 Adelphi Road; College Park, MD 20740–6001.

■ *Hand delivery or courier:* Deliver comments to front desk at 8601 Adelphi Road, College Park, MD, addressed to: Regulations Comments Desk, External Policy Program; Suite 4100.

FOR FURTHER INFORMATION CONTACT: For information or questions about the regulation and the comments process, contact Kimberly Keravuori, External Policy Program Manager, by email at *regulation_comments@nara.gov,* or by telephone at 301.837.3151.

SUPPLEMENTARY INFORMATION:

Regulatory Analysis

Review Under Executive Orders 12866 and 13563

Executive Order 12866, Regulatory Planning and Review, 58 FR 51735 (September 30, 1993), and Executive Order 13563, Improving Regulation and Regulation Review, 76 FR 23821 (January 18, 2011), direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). This rule is not ''significant'' under section 3(f) of Executive Order 12866 because it proposes to make only minor administrative revisions. The Office of Management and Budget (OMB) has reviewed this regulation.

Review Under the Regulatory Flexibility Act (5 U.S.C. 601, *et seq*.)

This review requires an agency to prepare an initial regulatory flexibility analysis and publish it when the agency publishes the rule. This requirement does not apply if the agency certifies that the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities (5 U.S.C. 603). NARA certifies, after review and analysis, that this rule will not have a significant adverse economic impact on small entities because it makes only minor administrative changes to the rule and the rule governs how people may access these records, which does not impact small entities.

Review Under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq*.)

This rule does not contain information collection activities that are subject to review and approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Review Under Executive Order 13132, Federalism, 64 FR 43255 (August 4, 1999)

Review under Executive Order 13132 requires that agencies review regulations for Federalism effects on the institutional interest of states and local governments, and, if the effects are sufficiently substantial, prepare a Federal assessment to assist senior policy makers. This rule will not have any direct effects on State and local governments within the meaning of the Executive Order. Therefore, this regulation does not require a Federalism assessment.

List of Subjects in 36 CFR Part 1275

Access, Information, Presidential records.

For the reasons stated in the preamble, NARA revises 36 CFR part 1275 to read as follows:

PART 1275—PRESERVATION AND PROTECTION OF AND ACCESS TO THE PRESIDENTIAL HISTORICAL MATERIALS OF THE NIXON ADMINISTRATION

Sec.

Subpart A—General Provisions

1275.1 Scope and purpose.
1275.14 Legal custody.
1275.16 Definitions.

Subpart B—Preserving and Protecting Materials

1275.20 Responsibility.
1275.22 Security.

Subpart C—Special Access to Materials

1275.30 Access by designees or assignees of former President Nixon.
1275.32 Access by Federal agencies.
1275.34 Access for use in judicial proceedings.

Subpart D—Public Access to Materials

1275.42 Processing.
1275.44 Segregating and reviewing.
1275.46 Transfer of private or personal materials.
1275.48 Restriction of materials related to abuses of governmental power.
1275.50 Restriction of materials of general historical significance unrelated to abuses of governmental power.
1275.52 Periodic review of restrictions.
1275.54 Appeal of restrictions.
1275.56 Deleting restricted portions.
1275.58 Requests for declassification.
1275.60 Freedom of information Act (FOIA) requests.

Authority: 44 U.S.C. 2104, 2111 note.

Subpart A—General Provisions

§ 1275.1 Scope and purpose.

This part implements title I of the Presidential Recordings and Materials Preservation Act (PRMPA, 44 U.S.C. 2111 note) with respect to the Presidential historical materials of the Richard M. Nixon Administration (covering the period beginning January 20, 1969, and ending August 9, 1974). This part applies to all Nixon Presidential historical materials in the custody of the Archivist of the United States pursuant to the PRMPA, and prescribes policies and procedures by which the National Archives and Records Administration (NARA) preserves, protects, and provides access to them.

§ 1275.14 Legal custody.

The Archivist of the United States has or will obtain exclusive legal custody and control of all Presidential historical materials of the Nixon Administration held pursuant to the provisions of title I of the Presidential Recordings and Materials Preservation Act.

§ 1275.16 Definitions.

As used in part 1275, the following definitions apply:

(a) *Presidential historical materials.* The term *Presidential historical materials* (also referred to as *historical materials* and *materials*) means all papers, correspondence, documents, pamphlets, books, photographs, films, motion pictures, sound and video recordings, machine-readable media, plats, maps, models, pictures, works of art, and other objects or materials made or received by former President Richard M. Nixon or by members of his staff in connection with his constitutional or statutory powers or duties as President and retained or appropriate for retention as evidence of or information about these powers or duties. Included in this definition are materials relating to the political activities of former President Nixon or members of his staff, as well as matters relating to President Nixon's private political associations that have no connection with the constitutional or statutory powers or duties of the President or a member of his staff. Excluded from this definition are documentary materials of any type that are determined to be the official records of an agency of the Government; private or personal materials; stocks of publications, processed documents, and stationery; and extra copies of documents produced only for convenience or reference when they are clearly so identified.

(b) *Private or personal materials.* The term *private or personal materials* means those papers and other documentary or commemorative materials in any physical form relating solely to the personal and family issues of President Nixon, his family, and his

friends and that have no connection with his constitutional or statutory powers, or duties of the President or any member of the President's staff. (Materials relating to private political associations, including matters relating to the Republican Party and election campaigns, that have been donated to NARA by the Richard Nixon Library and Birthplace Foundation pursuant to a 2007 deed of gift are excluded from this definition.)

(c) *Abuses of governmental power popularly identified under the generic term ''Watergate.''* The term *abuses of governmental power popularly identified under the generic term ''Watergate''* (also referred to as *abuses of governmental power*), means those alleged acts, whether or not corroborated by judicial, administrative, or legislative proceedings, which allegedly were conducted, directed, or approved by President Richard M. Nixon, his staff, or persons associated with him in his constitutional or statutory functions as President, or as political activities directly relating to or having a direct effect upon those functions, and which:

(1) Were within the purview of the charters of the Senate Select Committee on Presidential Campaign Activities or the Watergate Special Prosecution Force; or

(2) Are described in the Articles of Impeachment adopted by the House Committee on the Judiciary and reported to the House of Representatives for consideration in House Report No. 93–1305.

(d) *General historical significance.* The term *general historical significance* means having administrative, legal, research, or other historical value as evidence of or information about the constitutional or statutory powers or duties of the President, which an archivist has determined is of a quality sufficient to warrant the retention by the United States of materials so designated.

(e) *Archivist.* The term *Archivist* means the Archivist of the United States or the Archivist's designated agent. The term *archivist* means an employee of NARA who, by education or experience, is specially trained in archival science.

(f) *Agency.* The term *agency* means an executive department, military department, independent regulatory or non-regulatory agency, Government corporation, Government-controlled corporation, or other establishment in the executive branch of the Government including the Executive Office of the President. For purposes of § 1275.32 only, the term *agency* also includes the White House Office.

(g) *Staff.* The term *staff* means those people whose salaries were paid fully or partially from appropriations to the White House Office or Domestic Council; who were detailed on a non-reimbursable basis to the White House Office or Domestic Council from any other Federal activity; who otherwise were designated as assistants to the President, in connection with their service in that capacity; or whose files were sent to the White House Central Files Unit or Special Files Unit, for purposes of those files.

(h) *Classified national security information.* The term *classified national security information* means any matter which is designated as classified under applicable law, or under E.O. 13526, Classified National Security Information (December 29, 2009), or its successors.

Subpart B—Preserving and Protecting Materials

§ 1275.20 Responsibility.

The Archivist is responsible for the preservation and protection of the Nixon Presidential historical materials.

§ 1275.22 Security.

The Archivist is responsible for providing adequate security for the Presidential historical materials, and for establishing access procedures.

Subpart C—Special Access to Materials

§ 1275.30 Access by designees or assignees of former President Nixon.

In accordance with subpart B of this part, former President Richard M. Nixon's designated or assigned agent(s) at all times have access to Presidential historical materials in the custody and control of the Archivist.

§ 1275.32 Access by Federal agencies.

In accordance with subpart B of this part, any Federal agency in the executive branch has access for lawful Government use to the Presidential historical materials in the custody and control of the Archivist to the extent necessary for ongoing Government business. The Archivist will consider only written requests from heads of agencies or departments, deputy heads of agencies or departments, or heads of major organizational components or functions within agencies or departments.

§ 1275.34 Access for use in judicial proceedings.

In accordance with subpart B of this part, and subject to any rights, defenses, or privileges which the Federal Government or any person may invoke, the Presidential historical materials in the custody and control of the Archivist will be made available for use in any judicial proceeding and are subject to subpoena or other lawful process.

Subpart D—Public Access to Materials

§ 1275.42 Processing.

The archivists will conduct archival processing of all closed materials to prepare them for public access. In processing the materials, the archivists will give priority to segregating private or personal materials and transferring them to their proprietary or commemorative owners in accordance with § 1275.46. In conducting such archival processing, the archivists will restrict portions of the materials pursuant to §§ 1275.48 and 1275.50. All materials will be prepared for public access and released subject to restrictions or outstanding claims or petitions seeking such restrictions.

§ 1275.44 Segregating and reviewing.

(a) During the processing period described in § 1275.42, the Archivist will assign archivists to segregate private or personal materials, as defined in § 1275.16(b). The archivists have sole responsibility for the initial review and determination of private or personal materials. At all times when the archivists or other authorized officials have access to the materials in accordance with these regulations, they will take all reasonable steps to minimize the degree of intrusion into private or personal materials. Except as provided in these regulations, the archivists or other authorized officials will not disclose to any person private or personal or otherwise restricted information learned as a result of their activities under these regulations.

(b) During the processing period described in § 1275.42, the Archivist will assign archivists to segregate materials neither relating to abuses of governmental power, as defined in § 1275.16(c), nor otherwise having general historical significance, as defined in § 1275.16(d). The archivists have sole responsibility for the initial review and determination of those materials which are not related to abuses of governmental power and do not otherwise have general historical significance.

(c) During the processing period described in § 1275.42, the Archivist will assign archivists to segregate materials subject to restriction, as prescribed in §§ 1275.48 and 1275.50. The archivists have sole responsibility for the initial review and determination

of materials that should be restricted. The archivists insert a notification of withdrawal at the front of the file folder or container affected by the removal of restricted material. The notification includes a brief description of the restricted material and the basis for the restriction as prescribed in §§ 1275.48 and 1275.50.

§ 1275.46 Transfer of private or personal materials.

(a) The Archivist will transfer sole custody and use of those materials determined to be private or personal, or to be neither related to abuses of governmental power nor otherwise of general historical significance, to Richard Nixon's heirs or to the former staff member who created the materials having primary proprietary or commemorative interest in the materials, or to their heir, designee, or assignee. Such materials include all segments of the original tape recordings that have been or will be identified as private or personal.

(b) Materials determined to be neither related to abuses of governmental power nor otherwise of general historical significance, and transferred pursuant to paragraph (a) of this section, will upon such transfer no longer be deemed Presidential historical materials as defined in § 1275.16(a).

§ 1275.48 Restriction of materials related to abuses of governmental power.

(a) The Archivist will restrict access to materials determined during the processing period to relate to abuses of governmental power, as defined in § 1275.16(c), when:

(1) Ordered by a court;

(2) The release of the materials would violate a Federal statute; or

(3) The materials are authorized under criteria established by executive order to be kept secret in the interest of national defense or foreign policy, provided that any question as to whether materials are in fact properly classified or are properly subject to classification will be resolved in accordance with the applicable executive order or as otherwise provided by law.

(b) However, the Archivist may waive these restrictions when:

(1) The requester is engaged in a historical research project; *or*

(2) The requester is a former Federal official who had been appointed by President Nixon to a policymaking position and who seeks access to only those classified materials which he originated, reviewed, signed, or received while in public office; *and*

(3) The requester has a security clearance equivalent to the highest degree of national security classification that may be applicable to any of the materials to be examined; *and*

(4) The Archivist has determined that the heads of agencies having subject matter interest in the material do not object to the granting of access to the materials; *and*

(5) The requester has signed a statement, which declares that the requester will not publish, disclose, or otherwise compromise the classified material to be examined and that the requester has been made aware of Federal criminal statutes which prohibit the compromise or disclosure of this information.

(c) The Archivist will restrict access to any portion of materials determined to relate to abuses of governmental power when the release of those portions would constitute a clearly unwarranted invasion of personal privacy or constitute libel of a living person: *Provided,* That if material related to an abuse of governmental power refers to, involves, or incorporates such personal information, the Archivist will make available such personal information, or portions thereof, if such personal information, or portions thereof, is essential to an understanding of the abuses of governmental power.

§ 1275.50 Restriction of materials of general historical significance unrelated to abuses of governmental power.

(a) The Archivist will restrict access to materials determined during the processing period to be of general historical significance, but not related to abuses of governmental power, under one or more of the circumstances specified in § 1275.48(a).

(b) The Archivist will also restrict access to materials of general historical significance, but not related to abuses of governmental power, when the release of these materials would:

(1) Disclose trade secrets and commercial or financial information obtained from a person and privileged or confidential; or

(2) Constitute a clearly unwarranted invasion of personal privacy of a living person; or

(3) Disclose investigatory materials compiled for law enforcement purposes, but only when the disclosure of such records would:

(i) Interfere with enforcement proceedings;

(ii) Deprive a person of a right to a fair trial or an impartial adjudication;

(iii) Constitute an unwarranted invasion of personal privacy;

(iv) Disclose the identity of a confidential source who furnished information on a confidential basis, and in the case of a record compiled by a criminal law enforcement authority in the course of a criminal investigation or by an agency conducting a lawful national security intelligence investigation, confidential information furnished by a confidential source;

(v) Disclose techniques and procedures for law enforcement investigations or prosecutions, or disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law; or

(vi) Endanger the life or physical safety of any individual.

§ 1275.52 Periodic review of restrictions.

The Archivist periodically will assign archivists to review materials placed under restriction by § 1275.48 or § 1275.50 and to make available for public access those materials which, with the passage of time or other circumstances, no longer require restriction.

§ 1275.54 Appeal of restrictions.

The Nixon Presidential Library controls the Nixon Presidential historical materials. Upon petition of any researcher who claims in writing to the library director that the restriction of specified materials is inappropriate and should be removed, the archivists will submit the pertinent materials, or representative examples of them, to the library director. The library director reviews the restricted materials, and consults with interested Federal agencies as necessary. To the extent these consultations require the transfer of copies of materials to Federal officials outside NARA, the library director will comply with the requirements of § 1275.32. As necessary and practicable, the library director will also seek the views of any person whose rights or privileges might be adversely affected by a decision to open the materials. The library director prepares a final written decision as to the continued restriction of all or part of the pertinent materials. The library director's decision constitutes the final administrative determination. The library director will notify the petitioner and other interested people of the final administrative determination within 60 calendar days following receipt of such petition.

§ 1275.56 Deleting restricted portions.

The Archivist will provide a requester any reasonably segregable portions of otherwise restricted materials after NARA deletes the portions which are restricted under § 1275.48 or § 1275.50.

§ 1275.58 Requests for declassification.

Challenges to the classification and requests for the declassification of national security classified materials are governed by the provisions of 36 CFR part 1256, subpart E, as that may be amended from time to time.

§ 1275.60 Freedom of Information Act (FOIA) requests.

(a) The Archivist will process Freedom of Information Act (FOIA) requests for access to only those materials within the Presidential historical materials that are identifiable by an archivist as records of an agency as defined in § 1275.16(f). The Archivist will process these requests in accordance with the FOIA regulations set forth in 36 CFR part 1250, NARA Records Subject to FOIA.

(b) In order to allow NARA archivists to devote as much time and effort as possible to the processing of materials for general public access, the Archivist will not process those FOIA requests where the requester can reasonably obtain the same materials through a request directed to an agency (as defined in § 1275.16(f)), unless the requester demonstrates that he or she has unsuccessfully sought access from that agency or its successor in law or function.

Dated: March 2, 2016.

David S. Ferriero,

Archivist of the United States.

[FR Doc. 2016–05149 Filed 3–7–16; 8:45 am]

BILLING CODE 7515–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2014–0194; FRL–9942–24]

Amitraz, Carfentrazone-ethyl, Ethephon, Malathion, Mancozeb, et al.; Tolerance Actions; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; correction.

SUMMARY: EPA issued a document in the **Federal Register** of November 20, 2015, concerning the removal of the entry ''Rice, straw'' from the table in 40 CFR 180.361(a). EPA subsequently issued a document in the **Federal Register** of December 21, 2015, which redesignated 40 CFR 180.361(a) as 40 CFR 180.361(a)(1). This document corrects the document published on November 20, 2015, to remove the entry ''Rice, straw'' from the table in paragraph (a)(1).

DATES: This final rule correction is effective May 18, 2016.

FOR FURTHER INFORMATION CONTACT: Susan Lewis, Registration Division (7505P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001; telephone number: (703) 305–7090; email address: *RDFRNotices@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

The Agency included in the November 20, 2015 document a list of those who may be potentially affected by this action.

B. How can I get copies of this document and other related information?

The dockets for this action, identified by docket identification (ID) number EPA–HQ–OPP–2014–0194 are available at *http://www.regulations.gov* or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW., Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the OPP Docket is (703) 305–5805. Please review the visitor instructions and additional information about the dockets available at *http://www.epa.gov/dockets.*

II. What does this correction do?

The final rule in the **Federal Register** of November 20, 2015, amended 40 CFR 180.361 to remove the entry ''Rice, straw'' from the table in paragraph (a). In the final rule in the **Federal Register** of December 21, 2015 (80 FR 79267) (FRL–9937–18), paragraph (a) was redesignated as paragraph (a)(1) so we are amending 40 CFR 180.361 to remove the entry ''Rice, straw'' from the table in paragraph (a)(1).

FR Doc. 2015–28491 published in the **Federal Register** of November 20, 2015 (80 FR 72593) (FRL–9935–01) is corrected as follows:

§ 180.361 [Amended]

■ 1. On page 72598, second column, under the heading § 180.361 [Amended], instruction 16, line 3, correct paragraph (a) to read paragraph (a)(1).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: February 25, 2016.

Susan Lewis,

Director, Registration Division, Office of Pesticide Programs.

[FR Doc. 2016–04765 Filed 3–7–16; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2014–0922; FRL–9942–18]

Zoxamide; Pesticide Tolerances

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes tolerances for residues of zoxamide in or on the tomato subgroup 8–10A, the small, vine climbing fruit, except fuzzy kiwifruit, subgroup 13–07F, the tuberous and corm vegetable subgroup 1C and ginseng. Interregional Research Project Number 4 (IR–4) requested these tolerances under the Federal Food, Drug, and Cosmetic Act (FFDCA).

DATES: This regulation is effective March 8, 2016. Objections and requests for hearings must be received on or before May 9, 2016, and must be filed in accordance with the instructions provided in 40 CFR part 178 (see also Unit I.C. of the **SUPPLEMENTARY INFORMATION**).

ADDRESSES: The docket for this action, identified by docket identification (ID) number EPA–HQ–OPP–2014–0922, is available at *http://www.regulations.gov* or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW., Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the OPP Docket is (703) 305–5805. Please review the visitor instructions and additional information about the docket available at *http://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: Susan Lewis, Registration Division (7505P), Office of Pesticide Programs,

Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001; main telephone number: (703) 305–7090; email address: *RDFRNotices@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. The following list of North American Industrial Classification System (NAICS) codes is not intended to be exhaustive, but rather provides a guide to help readers determine whether this document applies to them. Potentially affected entities may include:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

B. How can I get electronic access to other related information?

You may access a frequently updated electronic version of EPA's tolerance regulations at 40 CFR part 180 through the Government Printing Office's e-CFR site at *http://www.ecfr.gov/cgi-bin/text-idx?&c=ecfr&tpl=/ecfrbrowse/Title40/40tab_02.tpl*.

C. How can I file an objection or hearing request?

Under FFDCA section 408(g), 21 U.S.C. 346a, any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. You must file your objection or request a hearing on this regulation in accordance with the instructions provided in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket ID number EPA–HQ–OPP–2014–0922 in the subject line on the first page of your submission. All objections and requests for a hearing must be in writing, and must be received by the Hearing Clerk on or before May 9, 2016. Addresses for mail and hand delivery of objections and hearing requests are provided in 40 CFR 178.25(b).

In addition to filing an objection or hearing request with the Hearing Clerk as described in 40 CFR part 178, please submit a copy of the filing (excluding any Confidential Business Information (CBI)) for inclusion in the public docket. Information not marked confidential pursuant to 40 CFR part 2 may be disclosed publicly by EPA without prior notice. Submit the non-CBI copy of your objection or hearing request, identified by docket ID number EPA–HQ–OPP–2014–0922, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be CBI or other information whose disclosure is restricted by statute.
- *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *http://www.epa.gov/dockets/contacts.html*.

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets*.

II. Summary of Petitioned-For Tolerance

In the **Federal Register** of April 6, 2015 (80 FR 18327) (FRL–9924–00), EPA issued a document pursuant to FFDCA section 408(d)(3), 21 U.S.C. 346a(d)(3), announcing the filing of a pesticide petition (PP 4E8335) by IR–4, 500 College Road East, Suite 201 W., Princeton, NJ 08540. The petition requested that 40 CFR part 180 be amended by establishing tolerances for residues of residues of the sum of zoxamide (3, 5-dichloro-N-(3-chloro-1-ethyl-1-methyl-2-oxopropyl)-4-methylbenzamide) and its metabolites 3,5-dichloro-1,4-benzenedicarboxylic acid (RH–1455 and RH–141455) and 3,5-dichloro-4-hydroxymethylbenzoic acid (RH–1452 and RH–141452) calculated as the stoichiometric equivalent of zoxamide in or on the raw agricultural commodity ginseng at 0.30 parts per million (ppm) and vegetable, tuberous and corm, subgroup 1C at 0.060 ppm. In addition, IR–4 requested to establish tolerances for residues, determined by measuring only zoxamide (3,5-dichloro-N-(3-chloro-1-ethyl-1-methyl-2-oxypropyl)-4-methylbenzamide, in or on the raw agricultural commodity tomato subgroup 8–10A at 2.0 ppm and fruit, small, vine climbing, except fuzzy kiwifruit, subgroup 13–07F at 5.0 ppm. IR–4 also proposed, upon the approval of the aforementioned tolerances, to remove established tolerances for grape at 3.0 ppm; tomato at 2.0 ppm; and potato at 0.060 ppm. That document referenced a summary of the petition prepared by Gowan Company, the registrant, which is available in the docket, *http://www.regulations.gov*. There were no comments received in response to the notice of filing.

III. Aggregate Risk Assessment and Determination of Safety

Section 408(b)(2)(A)(i) of FFDCA allows EPA to establish a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the tolerance is ''safe.'' Section 408(b)(2)(A)(ii) of FFDCA defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and in residential settings, but does not include occupational exposure. Section 408(b)(2)(C) of FFDCA requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue. . . .''

Consistent with FFDCA section 408(b)(2)(D), and the factors specified in FFDCA section 408(b)(2)(D), EPA has reviewed the available scientific data and other relevant information in support of this action. EPA has sufficient data to assess the hazards of and to make a determination on aggregate exposure for zoxamide including exposure resulting from the tolerances established by this action. EPA's assessment of exposures and risks associated with zoxamide follows.

A. Toxicological Profile

EPA has evaluated the available toxicity data and considered its validity, completeness, and reliability as well as the relationship of the results of the studies to human risk. EPA has also considered available information concerning the variability of the sensitivities of major identifiable subgroups of consumers, including infants and children.

In repeat dose oral and dermal toxicity studies in rats, there were no indications of systemic toxicity up to the highest dose tested (HDT); most of the highest doses were at or above the limit dose (1,000 milligrams/kilogram/day (mg/kg/day)). In the repeat dose oral toxicity studies in dogs, effects included increased liver and thyroid weights, liver histopathology (*i.e.,* hepatocellular hypertrophy), and increased alkaline phosphatase.

In the rat and rabbit prenatal developmental toxicity studies, there were no indications of susceptibility, as there was neither maternal nor developmental toxicity up to the HDT. In the rat reproduction study, there were no indications of susceptibility, since parental effects (*i.e.,* decreased maternal body weight) occurred in the absence of reproductive or offspring toxicity.

Zoxamide has been classified as ''not likely to be carcinogenic in humans'' based on the results of carcinogenicity studies in rats and mice. In the acute and subchronic neurotoxicity studies, there were no indications of neurotoxicity up to the HDT.

Specific information on the studies received and the nature of the adverse effects caused by zoxamide as well as the no-observed-adverse-effect-level (NOAEL) and the lowest-observed-adverse-effect-level (LOAEL) from the toxicity studies can be found at *http://www.regulations.gov* in the document titled ''*Zoxamide. Human Health Aggregate Risk Assessment for the Proposed New Uses on Ginseng, Tomato Subgroup 8–10A; Small Fruit, Vine Climbing, Except Fuzzy Kiwifruit, Subgroup 13–07F; and Tuberous and Corm Vegetable Subgroup 1C''* on page 25 in docket ID number EPA–HQ–OPP–2014–0922.

B. Toxicological Points of Departure/Levels of Concern

Once a pesticide's toxicological profile is determined, EPA identifies toxicological points of departure (POD) and levels of concern to use in evaluating the risk posed by human exposure to the pesticide. For hazards that have a threshold below which there is no appreciable risk, the toxicological POD is used as the basis for derivation of reference values for risk assessment. PODs are developed based on a careful analysis of the doses in each toxicological study to determine the dose at which no adverse effects are observed (the NOAEL) and the lowest dose at which adverse effects of concern are identified (the LOAEL). Uncertainty/safety factors are used in conjunction with the POD to calculate a safe exposure level—generally referred to as a population-adjusted dose (PAD) or a reference dose (RfD)—and a safe margin of exposure (MOE). For non-threshold risks, the Agency assumes that any amount of exposure will lead to some degree of risk. Thus, the Agency estimates risk in terms of the probability of an occurrence of the adverse effect expected in a lifetime. For more information on the general principles EPA uses in risk characterization and a complete description of the risk assessment process, see *http://www2.epa.gov/pesticide-science-and-assessing-pesticide-risks/assessing-human-health-risk-pesticides.*

A summary of the toxicological endpoints for zoxamide used for human risk assessment is discussed in Unit III.B. of the final rule published in the **Federal Register** of July 18, 2014 (79 FR 41911) (FRL–9913–35).

C. Exposure Assessment

1. *Dietary exposure from food and feed uses.* In evaluating dietary exposure to zoxamide, EPA considered exposure under the petitioned-for tolerances as well as all existing zoxamide tolerances in 40 CFR 180.567. EPA assessed dietary exposures from zoxamide in food as follows:

i. *Acute exposure.* Quantitative acute dietary exposure and risk assessments are performed for a food-use pesticide, if a toxicological study has indicated the possibility of an effect of concern occurring as a result of a 1-day or single exposure.

No such effects were identified in the toxicological studies for zoxamide; therefore, a quantitative acute dietary exposure assessment is unnecessary.

ii. *Chronic exposure.* In conducting the chronic dietary exposure assessment EPA used the food consumption data from the United States Department of Agriculture's (USDA's) 2003–2008 National Health and Nutrition Examination Survey, What We Eat in America (NHANES/WWEIA) database. As to residue levels in food, EPA assumed tolerance-level residues and 100 percent crop treated (PCT) for all established and proposed commodities. The assessment also utilized default processing factors from the Dietary Exposure Evaluation Model—Food Commodity Intake Database (DEEM–FCID) version 7.81 except for raisin and potato granules/flakes, where the processing factor was set at 1.

iii. *Cancer.* Based on the data summarized in Unit III.A., EPA has concluded that zoxamide does not pose a cancer risk to humans. Therefore, a dietary exposure assessment for the purpose of assessing cancer risk is unnecessary.

iv. *Anticipated residue and PCT information.* EPA did not use anticipated residue or PCT information in the dietary assessment for zoxamide. Tolerance level residues and 100 PCT were assumed for all food commodities.

2. *Dietary exposure from drinking water.* The Agency used screening level water exposure models in the dietary exposure analysis and risk assessment for zoxamide and its major metabolites in drinking water. These simulation models take into account data on the physical, chemical, and fate/transport characteristics of zoxamide and its metabolites. Further information regarding EPA drinking water models used in pesticide exposure assessment can be found at *http://www2.epa.gov/pesticide-science-and-assessing-pesticide-risks/about-water-exposure-models-used-pesticide.*

Based on the Pesticide Root Zone Model/Exposure Analysis Modeling System (PRZM/EXAMS) and Pesticide Root Zone Model Ground Water (PRZM GW) model, the estimated drinking water concentrations (EDWCs) of zoxamide and its major metabolites for chronic exposures are estimated to be 22.84 parts per billion (ppb) for surface water and 65.8 ppb for ground water.

Modeled estimates of drinking water concentrations were directly entered into the dietary exposure model. For chronic dietary risk assessment, the water concentration of value 65.8 ppb was used to assess the contribution to drinking water.

3. *From non-dietary exposure.* The term ''residential exposure'' is used in this document to refer to non-occupational, non-dietary exposure (*e.g.,* for lawn and garden pest control, indoor pest control, termiticides, and flea and tick control on pets). Zoxamide is not registered for any specific use patterns that would result in residential exposure.

4. *Cumulative effects from substances with a common mechanism of toxicity.* Section 408(b)(2)(D)(v) of FFDCA requires that, when considering whether to establish, modify, or revoke a tolerance, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.''

EPA has not found zoxamide to share a common mechanism of toxicity with any other substances, and zoxamide does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has assumed that zoxamide does not have a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see EPA's Web site at *http://www2.epa.gov/pesticide-science-and-assessing-pesticide-risks/cumulative-assessment-risk-pesticides.*

D. Safety Factor for Infants and Children

1. *In general.* Section 408(b)(2)(C) of FFDCA provides that EPA shall apply an additional tenfold (10x) margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the database on toxicity and exposure unless EPA determines based on reliable data that a different margin of safety will be safe for infants and children. This additional margin of safety is commonly referred to as the Food Quality Protection Act Safety Factor (FQPA SF). In applying this provision, EPA either retains the default value of 10x, or uses a different additional safety factor when reliable data available to EPA support the choice of a different factor.

2. *Prenatal and postnatal sensitivity.* There was no evidence for increased susceptibility following prenatal exposure in prenatal developmental toxicity studies in rats and rabbits. Additionally, there was no evidence for increased susceptibility following pre- or postnatal exposure in the reproduction and fertility effects study in rats.

3. *Conclusion.* EPA has determined that reliable data show the safety of infants and children would be adequately protected if the FQPA SF were reduced to 1×. That decision is based on the following findings:

i. The toxicity database for zoxamide is complete.

ii. There is no indication that zoxamide is a neurotoxic chemical and there is no need for a developmental neurotoxicity study or additional UFs to account for neurotoxicity.

iii. There is no evidence that zoxamide results in increased susceptibility in *in utero* rats or rabbits in the prenatal developmental studies or in young rats in the 2-generation reproduction study.

iv. There are no residual uncertainties identified in the exposure databases. The dietary food exposure assessments were performed based on 100 PCT and tolerance-level residues. EPA made conservative (protective) assumptions in the ground and surface water modeling used to assess exposure to zoxamide in drinking water. These assessments will not underestimate the exposure and risks posed by zoxamide.

E. Aggregate Risks and Determination of Safety

EPA determines whether acute and chronic dietary pesticide exposures are safe by comparing aggregate exposure estimates to the acute PAD (aPAD) and chronic PAD (cPAD). For linear cancer risks, EPA calculates the lifetime probability of acquiring cancer given the estimated aggregate exposure. Short-, intermediate-, and chronic-term risks are evaluated by comparing the estimated aggregate food, water, and residential exposure to the appropriate PODs to ensure that an adequate MOE exists.

1. *Acute risk.* An acute aggregate risk assessment takes into account acute exposure estimates from dietary consumption of food and drinking water. No adverse effect resulting from a single oral exposure was identified and no acute dietary endpoint was selected. Therefore, zoxamide is not expected to pose an acute risk.

2. *Chronic risk.* Using the exposure assumptions described in this unit for chronic exposure, EPA has concluded that chronic exposure to zoxamide from food and water will utilize 6.3% of the cPAD for children 1–2 years old, the population group receiving the greatest exposure. There are no residential uses for zoxamide.

3. *Short- and intermediate-term risk.* Short- and intermediate-term aggregate exposure takes into account short- and intermediate-term residential exposure plus chronic exposure to food and water (considered to be a background exposure level).

A short- and intermediate-term adverse effect was identified; however, zoxamide is not registered for any use patterns that would result in either short- or intermediate-term residential exposure. Short- and intermediate-term risk is assessed based on short- and intermediate-term residential exposure plus chronic dietary exposure. Because there is no short- or intermediate-term residential exposure and chronic dietary exposure has already been assessed under the appropriately protective cPAD (which is at least as protective as the POD used to assess short- or intermediate-term risk), no further assessment of short- or intermediate-term risk is necessary, and EPA relies on the chronic dietary risk assessment for evaluating short- and intermediate-term risk for zoxamide.

4. *Aggregate cancer risk for U.S. population.* Based on the lack of evidence of carcinogenicity in two adequate rodent carcinogenicity studies, zoxamide is not expected to pose a cancer risk to humans.

5. *Determination of safety.* Based on these risk assessments, EPA concludes that there is a reasonable certainty that no harm will result to the general population, or to infants and children from aggregate exposure to zoxamide residues.

IV. Other Considerations

A. Analytical Enforcement Methodology

Adequate enforcement methodology (Gas chromatography with electron capture detection (GC/ECD) and GC with mass selective detection (GC/MSD)) is available to enforce the tolerance expression.

The method may be requested from: Chief, Analytical Chemistry Branch, Environmental Science Center, 701 Mapes Rd., Ft. Meade, MD 20755–5350; telephone number: (410) 305–2905; email address: *residuemethods@epa.gov.*

B. International Residue Limits

In making its tolerance decisions, EPA seeks to harmonize U.S. tolerances with international standards whenever possible, consistent with U.S. food safety standards and agricultural practices. EPA considers the international maximum residue limits (MRLs) established by the Codex Alimentarius Commission (Codex), as required by FFDCA section 408(b)(4). The Codex Alimentarius is a joint United Nations Food and Agriculture Organization/World Health Organization food standards program, and it is recognized as an international food safety standards-setting organization in trade agreements to which the United States is a party. EPA may establish a tolerance that is different from a Codex MRL; however, FFDCA section 408(b)(4) requires that EPA explain the reasons for departing from the Codex level.

The tolerances being established for the tomato subgroup 8–10A and the small vine climbing fruit, except fuzzy kiwifruit, subgroup 13–07F are harmonized with established Codex MRLs on tomato and grape, respectively. The tolerance being established for the tuberous and corm vegetable subgroup 1C at 0.06 ppm is not harmonized with a Codex MRL on potato at 0.02 ppm. The underlying residue data and residue definition used to support the Subgroup 1C tolerance supports a tolerance recommendation that is higher than the established Codex MRL on potato at 0.02 ppm. There is not a Codex MRL for ginseng.

V. Conclusion

Therefore, tolerances are established for residues of zoxamide (3,5-dichloro-N-(3-chloro-1-ethyl-1-methyl-2-oxopropyl)-4-methylbenzamide) and its metabolites 3,5-dichloro-1,4-benzenedicarboxylic acid (RH–1455 and RH–141455) and 3,5-dichloro-4-hydroxymethylbenzoic acid (RH–1452 and RH–141452) calculated as the

stoichiometric equivalent of zoxamide in or on the raw agricultural commodity ginseng at 0.30 ppm and vegetable, tuberous and corm, subgroup 1C at 0.06 ppm. In addition, tolerances are established for residues, determined by measuring only zoxamide (3,5-dichloro-N-(3-chloro-1-ethyl-1-methyl-2-oxypropyl)-4-methylbenzamide, in or on raw agricultural commodity tomato subgroup 8–10A at 2.0 ppm and fruit, small vine climbing, except fuzzy kiwifruit, subgroup 13–07F at 5.0 ppm. Lastly, upon the establishment of the aforementioned tolerances, the established tolerances for grape at 3.0 ppm; tomato at 2.0 ppm; and potato at 0.060 ppm are removed as unnecessary.

VI. Statutory and Executive Order Reviews

This action establishes tolerances under FFDCA section 408(d) in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled ''Regulatory Planning and Review'' (58 FR 51735, October 4, 1993). Because this action has been exempted from review under Executive Order 12866, this action is not subject to Executive Order 13211, entitled ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001) or Executive Order 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997). This action does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), nor does it require any special considerations under Executive Order 12898, entitled ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations'' (59 FR 7629, February 16, 1994).

Since tolerances and exemptions that are established on the basis of a petition under FFDCA section 408(d), such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), do not apply.

This action directly regulates growers, food processors, food handlers, and food retailers, not States or tribes, nor does this action alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4). As such, the Agency has determined that this action will not have a substantial direct effect on States or tribal governments, on the relationship between the national government and the States or tribal governments, or on the distribution of power and responsibilities among the various levels of government or between the Federal Government and Indian tribes. Thus, the Agency has determined that Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999) and Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 9, 2000) do not apply to this action. In addition, this action does not impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note).

VII. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: February 25, 2016.

Susan Lewis,

Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

■ 1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

■ 2. In § 180.567:

■ a. In the table in paragraph (a)(1):

■ i. Add alphabetically entries for ''Fruit, small vine climbing'' and ''Tomato subgroup 8–10A''; and

■ ii. Remove the entries for ''Grape'' and ''Tomato''; and

■ b. In the table in paragraph (a)(2):

■ i. Add alphabetically entries for ''Ginseng'' and ''Vegetable, tuberous and corm''; and

■ ii. Remove the entry ''Potato''.

The additions read as follows:

§ 180.567 Zoxamide; tolerances for residues.

(a) * * *

(1) * * *

Commodity	Parts per million
Fruit, small vine climbing, except fuzzy kiwifruit, subgroup 13–07F	5.0
* * * * *	
Tomato subgroup 8–10A	2.0
* * * * *	

(2) * * *

Commodity	Parts per million
Ginseng	0.30
* * * * *	
Vegetable, tuberous and corm, subgroup 1C	0.06

* * * * *

[FR Doc. 2016–04740 Filed 3–7–16; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2015–0443; FRL–9943–21]

Fluopyram; Pesticide Tolerances

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes, amends, and deletes tolerances for residues of fluopyram in or on multiple commodities which are identified and discussed later in this document. Bayer CropScience requested these tolerances under the Federal Food, Drug, and Cosmetic Act (FFDCA).

DATES: This regulation is effective March 8, 2016. Objections and requests for hearings must be received on or before May 9, 2016, and must be filed in accordance with the instructions provided in 40 CFR part 178 (see also Unit I.C. of the **SUPPLEMENTARY INFORMATION**).

ADDRESSES: The docket for this action, identified by docket identification (ID)

number EPA–HQ–OPP–2015–0443, is available at *http://www.regulations.gov* or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW., Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the OPP Docket is (703) 305–5805. Please review the visitor instructions and additional information about the docket available at *http://www.epa.gov/dockets*.

FOR FURTHER INFORMATION CONTACT: Susan Lewis, Registration Division (7505P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001; main telephone number: (703) 305–7090; email address: *RDFRNotices@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. The following list of North American Industrial Classification System (NAICS) codes is not intended to be exhaustive, but rather provides a guide to help readers determine whether this document applies to them. Potentially affected entities may include:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

B. How can I get electronic access to other related information?

You may access a frequently updated electronic version of EPA's tolerance regulations at 40 CFR part 180 through the Government Printing Office's e-CFR site at *http://www.ecfr.gov/cgi-bin/text-idx?&c=ecfr&tpl=/ecfrbrowse/Title40/40tab_02.tpl*.

C. How can I file an objection or hearing request?

Under FFDCA section 408(g), 21 U.S.C. 346a, any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. You must file your objection or request a hearing on this regulation in accordance with the instructions provided in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket ID number EPA–HQ–OPP–2015–0443 in the subject line on the first page of your submission. All objections and requests for a hearing must be in writing, and must be received by the Hearing Clerk on or before May 9, 2016. Addresses for mail and hand delivery of objections and hearing requests are provided in 40 CFR 178.25(b).

In addition to filing an objection or hearing request with the Hearing Clerk as described in 40 CFR part 178, please submit a copy of the filing (excluding any Confidential Business Information (CBI)) for inclusion in the public docket. Information not marked confidential pursuant to 40 CFR part 2 may be disclosed publicly by EPA without prior notice. Submit the non-CBI copy of your objection or hearing request, identified by docket ID number EPA–HQ–OPP–2015–0443, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be CBI or other information whose disclosure is restricted by statute.
- *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *http://www.epa.gov/dockets*.

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets*.

II. Summary of Petitioned-For Tolerance

In the **Federal Register** of August 26, 2015 (80 FR 51759) (FRL–9931–74), EPA issued a document pursuant to FFDCA section 408(d)(3), 21 U.S.C. 346a(d)(3), announcing the filing of a pesticide petition (PP 4F8284) by Bayer CropScience, 2 T. W. Alexander Drive, Research Triangle Park, North Carolina 27709. The petition requested that 40 CFR 180.661 be amended by establishing tolerances for residues of the fungicide fluopyram in or on the raw agricultural commodities artichoke, globe at 4.0 parts per million; aspirated grain fractions at 50.0 ppm; peanut hay at 40.0 ppm; hops at 60.0 ppm; root vegetables, except beet, sugar, root, crop subgroup 1B at 0.30 ppm; tuberous and corm vegetables, crop subgroup 1C at 0.10 ppm; potato wet peel at 0.30 ppm; vegetables, leaves of root and tuber, crop group 2 at 30.0 ppm; bulb vegetables, bulb onion (crop subgroup 3–07A) at 0.30 ppm; bulb vegetables, green onions (crop subgroup 3–07B) at 15.0 ppm; leafy greens (crop subgroup 4A), without spinach at 20.0 ppm; leafy greens (crop subgroup 4A) spinach at 40.0 ppm; leafy petioles subgroup, celery (crop subgroup 4B) at 20.0 ppm; brassica leafy vegetables: Head and stem (crop subgroup 5A) at 4.0 ppm; brassica leafy vegetables: Leafy greens (crop subgroup 5B) at 50.0 ppm; soybean forage at 9.0 ppm; soybean hay at 30.0 ppm; legume vegetables: Edible podded (crop subgroup 6A) at 4.0 ppm; legume vegetables: Succulent shelled peas and beans (crop subgroup 6B) at 0.20 ppm; legume vegetables: Dried shelled peas and beans (crop subgroup 6C) at 0.70 ppm; vegetable, foliage of legume vegetables, forage, hay and vines, forage (crop group 7) at 90.0 ppm; fruiting vegetables, tomato subgroup (crop subgroup 8–10A) at 1.00 ppm; fruiting vegetables, pepper/eggplant subgroup (crop subgroup 8–10B) at 3.00 ppm; cucurbit vegetables (crop group 9A), melon subgroup at 0.90 ppm; cucurbit vegetables (crop group 9B), cucumber/squash subgroup at 0.30 ppm; citrus fruits (crop group 10–10) at 0.90 ppm; citrus oil at 8.0 ppm; pome fruit (crop group 11–10) at 2.0 ppm; stone fruit (crop group 12–12A), cherry subgroup at 2.00 ppm; stone fruit (crop group 12–12B), peach subgroup at 1.00 ppm; stone fruit (crop group 12–12C), plum subgroup at 0.50 ppm; berries and small fruit: Caneberry (crop subgroup 13–07A) at 5.0 ppm; berries and small fruit: Bushberry (crop subgroup 13–07B) at 7.0 ppm; raisins at 4.0 ppm; berries and small fruit, small fruit vine climbing, except fuzzy kiwi (crop subgroup 13–07F) at 1.5 ppm; berries and small fruit: Low growing berry (crop subgroup 13–07G) at 2.0 ppm; sorghum, grain at 1.5 ppm; wheat milled by-products at 2.0 ppm; grass forage, fodder and hay: Forage (crop group 17) at 80.0 ppm; herb crop (crop subgroup 19A) at 70.0 ppm; dill seed at 70.00 ppm; herbs, dried at 400 ppm; oilseeds, rapeseed, canola (crop subgroup 20A) at 0.70 ppm; oilseeds, sunflower, seed (crop subgroup 20B) at 0.70 ppm; and oilseeds: Cottonseed (crop subgroup 20C) at 0.80 ppm and in or on the animal commodities chicken, meat byproducts at 0.40 ppm; chicken, fat at 0.15 ppm; chicken, meat at 0.10 ppm; goat, fat at 4.00 ppm; and goat, meat at 4.00 ppm. Bayer CropScience also requests to establish a tolerance in 40 CFR 180.661 for indirect or inadvertent

residues of the fungicide fluopyram in or on the raw agricultural commodity sugarcane, cane at 0.08 ppm. The petition also requested to amend tolerances in 40 CFR 180.661 for residues of the fungicide fluopyram in or on the raw agricultural commodities peanut at 0.20 ppm; sugar beet, roots at 0.09 ppm; soybean, seed at 0.30 ppm; soybean forage at 9.0 ppm; soybean hay at 30.0 ppm; tree nuts (crop group 14) at 0.04 ppm; almond hulls at 10.00 ppm; grain, cereal, except rice and sorghum (crop group 15) at 0.90 ppm; cereal grain, except rice, forage, fodder and straw (crop group 16) at 20.0 ppm; and cotton gin by-product at 30.00 ppm and in or on the animal commodities cattle, meat byproducts at 40.00 ppm; cattle, fat at 4.00 ppm; cattle, meat at 4.00 ppm; milk, cattle at 2.00 ppm; eggs, chicken at 0.20 ppm; hog, meat byproducts at 0.40 ppm; hog, fat at 0.04 ppm; hog, meat at 0.04 ppm; horse, meat byproducts at 40.00 ppm; horse, fat at 4.00 ppm; horse, meat at 4.00 ppm; goat, meat byproducts at 40.00 ppm; sheep, meat byproducts at 40.00 ppm; sheep, fat at 4.00 ppm; and sheep, meat at 4.00 ppm. Bayer CropScience also requests to delete tolerances in 40 CFR 180.661 for residues of the fungicide fluopyram in or on the raw agricultural commodities apple at 0.30 ppm; bean, dry at 0.09 ppm; beet, sugar, roots at 0.04 ppm; apple wet pomace at 0.60 ppm; cherry at 0.60 ppm; grape, wine at 2.0 ppm; potato at 0.02 ppm; strawberry at 1.5 ppm; and watermelon at 1.0 ppm. That document referenced a summary of the petition prepared by Bayer CropScience, the registrant, which is available in the docket, *http://www.regulations.gov*. There were no comments received in response to the notice of filing.

Based upon review of the data supporting the petition, EPA is issuing some tolerances that vary from the fluopyram tolerances as requested. The reasons for these changes are explained in Unit IV.C.

III. Aggregate Risk Assessment and Determination of Safety

Section 408(b)(2)(A)(i) of FFDCA allows EPA to establish a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the tolerance is ''safe.'' Section 408(b)(2)(A)(ii) of FFDCA defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and in residential settings, but does not include occupational exposure. Section 408(b)(2)(C) of FFDCA requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue . . . .''

Consistent with FFDCA section 408(b)(2)(D), and the factors specified in FFDCA section 408(b)(2)(D), EPA has reviewed the available scientific data and other relevant information in support of this action. EPA has sufficient data to assess the hazards of and to make a determination on aggregate exposure for fluopyram including exposure resulting from the tolerances established by this action. EPA's assessment of exposures and risks associated with fluopyram follows.

A. Toxicological Profile

EPA has evaluated the available toxicity data and considered its validity, completeness, and reliability as well as the relationship of the results of the studies to human risk. EPA has also considered available information concerning the variability of the sensitivities of major identifiable subgroups of consumers, including infants and children.

Decreased body weight and liver effects were the common and frequent findings in the fluopyram subchronic and chronic oral toxicity studies in rats, mice, and dogs, and they appeared to be the most sensitive effects. Liver effects were characterized by increased liver weight, hepatocellular hypertrophy, hepatocellular vacuolation, increased mitosis and hepatocellular necrosis. Thyroid effects were found at dose levels similar to those that produced liver effects in rats and mice; these effects consisted of follicular cell hypertrophy, increased thyroid weight, and hyperplasia at dose levels greater than or equal to 100 milligrams/kilogram/day (mg/kg/day). Changes in thyroid hormone levels were also seen in a subchronic toxicity study. In male mice, there was an increased incidence of thyroid adenomas.

Although increased liver tumors were observed in female rats in the carcinogenicity study, EPA has concluded that fluopyram is ''Not Likely to be Carcinogenic to Humans'' at doses that do not induce cellular proliferation in the liver or thyroid glands. This classification was based on convincing evidence that non-genotoxic modes of action for liver tumors in rats and thyroid tumors in mice have been established and that the carcinogenic effects have been demonstrated as a result of a mode of action dependent on activation of the CAR/PXR receptors. The Agency is using a point of departure for regulating fluopyram (NOAEL of 1.2 mg/kg/day) that is below the doses that cause cell proliferation in the liver (11 mg/kg/day) and subsequent liver tumor formation (89 mg/kg/day); therefore, the Agency concludes that exposure to fluopyram will not be carcinogenic. Moreover, fluopyram is not genotoxic or mutagenic.

Fluopyram is not a developmental toxicant, nor did it adversely affect reproductive parameters. No evidence of qualitative or quantitative susceptibility was observed in developmental studies in rats and rabbits or in a multigeneration study in rats.

In an acute neurotoxicity study, transient decreased motor activity was seen only on the day of treatment, but no other findings demonstrating neurotoxicity were observed. In addition, no neurotoxicity was observed in the subchronic neurotoxicity study in the presence of other systemic adverse effects. Fluopyram did not produce treatment-related effects on the immune system.

Fluopyram has low acute toxicity via the oral, dermal, and inhalation routes of exposure. Fluopyram is not a skin or eye irritant or sensitizer under the conditions of the murine lymph node assay. Specific information on the studies received and the nature of the adverse effects caused by fluopyram as well as the no-observed-adverse-effect-level (NOAEL) and the lowest-observed-adverse-effect-level (LOAEL) from the toxicity studies can be found at *http://www.regulations.gov* in the document entitled: ''Fluopyram: Human Health Risk Assessment for Proposed New Uses on Crop Subgroup 1B, Subgroup 1C, Crop Group 2, Subgroup 3–07A, Subgroup 3–07B, Subgroup 4A, Subgroup 4B, Subgroup 5A, Subgroup 5B, Subgroup 6A, Subgroup 6B, Dried Beans, Soybean, Subgroup 8–10A, Subgroup 8–10B, Subgroup 9A, Subgroup 9B, Subgroup 10–10, Group 11–10, Subgroup 12–12A, Subgroup 12–12B, Subgroup 12–12C, Subgroup 13–07A, Subgroup 13–07B, Subgroup 13–07F, Subgroup 13–07G, Crop Group 15 (except corn and Rice), Crop Group 16, Subgroup 19A, Dill Seed, Subgroup 20A, Subgroup 20B, Subgroup 20C, Artichoke (Globe), Hops, and Sugarcane (Rotated). Amended Tolerance Requests for the Registered Uses due to Crop Group/Subgroup Expansion Requests. Proposed New Uses on Turf Grass, Ornamentals, and Christmas trees, and as a seed treatment to Peanuts'' in

docket ID number EPA–HQ–OPP–2015–0443.

B. Toxicological Points of Departure/Levels of Concern

Once a pesticide's toxicological profile is determined, EPA identifies toxicological points of departure (POD) and levels of concern to use in evaluating the risk posed by human exposure to the pesticide. For hazards that have a threshold below which there is no appreciable risk, the toxicological POD is used as the basis for derivation of reference values for risk assessment. PODs are developed based on a careful analysis of the doses in each toxicological study to determine the dose at which no adverse effects are observed (the NOAEL) and the lowest dose at which adverse effects of concern are identified (the LOAEL). Uncertainty/safety factors are used in conjunction with the POD to calculate a safe exposure level—generally referred to as a population-adjusted dose (PAD) or a reference dose (RfD)—and a safe margin of exposure (MOE). For non-threshold risks, the Agency assumes that any amount of exposure will lead to some degree of risk. Thus, the Agency estimates risk in terms of the probability of an occurrence of the adverse effect expected in a lifetime. For more information on the general principles EPA uses in risk characterization and a complete description of the risk assessment process, see *http://iaspub.epa.gov/apex/pesticides/f?p=chemicalsearch:1*.

A summary of the toxicological endpoints for fluopyram used for human risk assessment is shown in Table 1.

TABLE 1—SUMMARY OF TOXICOLOGICAL DOSES AND ENDPOINTS FOR FLUOPYRAM FOR USE IN HUMAN HEALTH RISK ASSESSMENT

Exposure/scenario	Point of departure and uncertainty/safety factors	RfD, PAD, LOC for risk assessment	Study and toxicological effects
Acute dietary (General population including infants and children).	NOAEL = 50 mg/kg/day. UF_A = 10x UF_H =10x FQPA SF = 1x	Acute RfD = 0.50 mg/kg/day. aPAD = 0.50 mg/kg/day.	Acute Neurotoxicity Study in Rats LOAEL = 100 mg/kg/day based on decreased motor and locomotor activity in females. The LOAEL in males was 125 mg/kg/day.
Acute dietary (Females 13–50 years of age).	An endpoint attributable to a single dose exposure has not been identified for this subpopulation.		
Chronic dietary (All populations)	NOAEL = 1.2 mg/kg/day. UF_A = 10x UF_H = 10x FQPA SF = 1x	Chronic RfD = 0.012 mg/kg/day. cPAD = 0.012 mg/kg/day.	Combined Chronic/Carcinogenicity in Rats LOAEL = 6.0 mg/kg/day based on follicular cell hypertrophy in the thyroid, and increased liver weight with gross pathological and histopathological findings.
Incidental oral short-term (1 to 30 days) and intermediate-term (1 to 6 months).	NOAEL = 14.5 mg/kg/day. UF_A = 10x UF_H = 10x FQPA SF = 1x	LOC for MOE = 100	Reproduction study in rats LOAEL = 82.8 mg/kg/day based on clinical pathology changes, decreased spleen and thymus weights, increased liver weight and centrilobular hypertrophy in parents, and decreased body weight and body weight gain with decreases in spleen and thymus weights and slight delay in preputial separation in offspring.
Dermal short-term (1 to 30 days) and intermediate-term (1 to 6 months).	NOAEL = 300 mg/kg/day. UF_A = 10x UF_H = 10x FQPA SF = 1x	Residential LOC for MOE = 100.	28-day dermal study in rats LOAEL = 1000 mg/kg/day based on increased cholesterol (F), increased prothrombin time (M).
Inhalation short-term (1 to 30 days) and intermediate-term (1–6 months).	NOAEL = 14.5 mg/kg/day. UF_A = 10x UF_H = 10x FQPA SF = 1x	Residential LOC for MOE = 100.	Reproduction study in rats LOAEL = 82.8 mg/kg/day based on clinical chemistry changes and increased kidney weight in parents, and decreased body weight and body weight gain with decreases in spleen and thymus weights in offspring.
Cancer (Oral, dermal, inhalation).	"Not Likely to be Carcinogenic to Humans" at doses that do not induce cellular proliferation in the liver or thyroid glands.		

FQPA SF = Food Quality Protection Act Safety Factor. LOAEL = lowest-observed-adverse-effect-level. LOC = level of concern. Mg/kg/day = milligram/kilogram/day. MOE = margin of exposure. NOAEL = no-observed-adverse-effect-level. PAD = population adjusted dose (a = acute, c = chronic). UF = uncertainty factor. UF_A = extrapolation from animal to human (interspecies). UF_H = potential variation in sensitivity among members of the human population (intraspecies).

C. Exposure Assessment

1. *Dietary exposure from food and feed uses.* In evaluating dietary exposure to fluopyram, EPA considered exposure under the petitioned-for tolerances as well as all existing fluopyram tolerances in 40 CFR 180.661. EPA assessed dietary exposures from fluopyram in food as follows:

i. *Acute exposure.* Quantitative acute dietary exposure and risk assessments are performed for a food-use pesticide, if a toxicological study has indicated the possibility of an effect of concern occurring as a result of a 1-day or single exposure. Such effects were identified for fluopyram. In estimating acute dietary exposure, EPA used food consumption information from the United States Department of Agriculture (USDA) 2003–2008 National Health and Nutrition Examination Survey/What We Eat in America (NHANES/WWEIA). As to residue levels in food, EPA included tolerance residue levels, the assumption

of 100% crop treated, and processing factors (empirical and default).

ii. *Chronic exposure.* In conducting the chronic dietary exposure assessment EPA used the food consumption data from the USDA 2003–2008 NHANES/WWEIA. As to residue levels in food, EPA included average residue levels, % crop treated, and processing factors (empirical and default).

iii. *Cancer.* Based on the data summarized in Unit III.A., EPA has concluded that fluopyram does not pose a cancer risk to humans at doses that do not induce cellular proliferation in the liver or thyroid glands. Therefore, a dietary exposure assessment for the purpose of assessing cancer risk is unnecessary.

iv. *Anticipated residue and percent crop treated (PCT) information.* Section 408(b)(2)(E) of FFDCA authorizes EPA to use available data and information on the anticipated residue levels of pesticide residues in food and the actual levels of pesticide residues that have been measured in food. If EPA relies on such information, EPA must require pursuant to FFDCA section 408(f)(1) that data be provided 5 years after the tolerance is established, modified, or left in effect, demonstrating that the levels in food are not above the levels anticipated. For the present action, EPA will issue such data call-ins as are required by FFDCA section 408(b)(2)(E) and authorized under FFDCA section 408(f)(1). Data will be required to be submitted no later than 5 years from the date of issuance of these tolerances.

Section 408(b)(2)(F) of FFDCA states that the Agency may use data on the actual percent of food treated for assessing chronic dietary risk only if:

- Condition a: The data used are reliable and provide a valid basis to show what percentage of the food derived from such crop is likely to contain the pesticide residue.
- Condition b: The exposure estimate does not underestimate exposure for any significant subpopulation group.
- Condition c: Data are available on pesticide use and food consumption in a particular area, the exposure estimate does not understate exposure for the population in such area.

In addition, the Agency must provide for periodic evaluation of any estimates used. To provide for the periodic evaluation of the estimate of PCT as required by FFDCA section 408(b)(2)(F), EPA may require registrants to submit data on PCT.

The Agency estimated the PCT for the chronic dietary exposure assessment for existing uses as follows:

Almonds 33%; apples 40%; blackberries 55%; blueberries 54%; broccoli 24%; cantaloupes 22%; celery 60%; corn field 9%; corn, sweet 15%; cucumbers 41%; dry beans/peas 7%; fresh tomatoes 64%; grape wine 79% (used for grape, wine and sherry); head lettuce 67%; leaf lettuce 62%; oranges 39%; peaches 56%; pears 43%; peanuts 67%; potatoes 64%; processed tomatoes 57%; pumpkins 45%; snap beans 44%; soybeans 17%; spinach 43%; squash 47%; strawberries 75%; sugar beets 48%; watermelons 54%; and wheat 17% (from spring wheat at 17% and winter wheat at 6%).

In most cases, EPA uses available data from United States Department of Agriculture/National Agricultural Statistics Service (USDA/NASS), proprietary market surveys, and the National Pesticide Use Database for the chemical/crop combination for the most recent 6–7 years. EPA uses an average PCT for chronic dietary risk analysis. The average PCT figure for each existing use is derived by combining available public and private market survey data for that use, averaging across all observations, and rounding to the nearest 5%, except for those situations in which the average PCT is less than one. In those cases, 1% is used as the average PCT and 2.5% is used as the maximum PCT. EPA uses a maximum PCT for acute dietary risk analysis. The maximum PCT figure is the highest observed maximum value reported within the recent 6 years of available public and private market survey data for the existing use and rounded up to the nearest multiple of 5%.

The Agency believes that the three conditions discussed in Unit III.C.1.iv. have been met. With respect to Condition a, PCT estimates are derived from federal and private market survey data, which are reliable and have a valid basis. The Agency is reasonably certain that the percentage of the food treated is not likely to be an underestimation. As to Conditions b and c, regional consumption information and consumption information for significant subpopulations is taken into account through EPA's computer-based model for evaluating the exposure of significant subpopulations including several regional groups. Use of this consumption information in EPA's risk assessment process ensures that EPA's exposure estimate does not understate exposure for any significant subpopulation group and allows the Agency to be reasonably certain that no regional population is exposed to residue levels higher than those estimated by the Agency. Other than the data available through national food consumption surveys, EPA does not have available reliable information on the regional consumption of food to which fluopyram may be applied in a particular area.

2. *Dietary exposure from drinking water.* The Agency used screening-level water exposure models in the dietary exposure analysis and risk assessment for fluopyram in drinking water. These simulation models take into account data on the physical, chemical, and fate/transport characteristics of fluopyram. Further information regarding EPA drinking water models used in pesticide exposure assessment can be found at *http://www.epa.gov/oppefed1/models/water/index.htm.*

Based on the Pesticide Root Zone Model Ground Water (PRZM GW) and the surface water concentration calculator (SWCC), the estimated drinking water concentrations (EDWCs) of fluopyram for acute exposures are estimated to be 50.6 parts per billion (ppb) for surface water and 97.6 ppb for ground water. The chronic exposures for non-cancer assessments are estimated to be 17.3 ppb for surface water and 90.5 ppb for ground water.

Modeled estimates of drinking water concentrations were directly entered into the dietary exposure model. For acute dietary risk assessment, the water concentration value of 97.6 ppb was used to assess the contribution to drinking water. For chronic dietary risk assessment, the water concentration of value 90.5 ppb was used to assess the contribution to drinking water.

3. *From non-dietary exposure.* The term ''residential exposure'' is used in this document to refer to non-occupational, non-dietary exposure (*e.g.,* for lawn and garden pest control, indoor pest control, termiticides, and flea and tick control on pets).

Fluopyram is proposed for use that could result in residential exposures: golf course turf, residential lawns, fruit trees, nut trees, ornamentals and gardens. EPA assessed residential exposure using the following assumptions: short-term dermal, oral (derived from incidental oral hand to mouth post-application exposures to treated lawn in children), and inhalation exposures derived from treating lawns by hose-end sprayers (adults); residential post-application exposures: adults and children (1 to <2 years old) dermal exposure to treated turf during high contact lawn activities; children (1 to <2 years old) incidental oral exposure as a result of contacting treated turf; adults and youths (11 to <16 yr old) dermal exposure to treated turf during mowing and golfing activities; children (6 to <11 years old) dermal exposure to treated turf during golfing activities; and adults and

children (6 to <11 years old) dermal exposure to treated gardens. Further information regarding EPA standard assumptions and generic inputs for residential exposures may be found at *http://www.epa.gov/pesticides/trac/science/trac6a05.pdf.*

4. *Cumulative effects from substances with a common mechanism of toxicity.* Section 408(b)(2)(D)(v) of FFDCA requires that, when considering whether to establish, modify, or revoke a tolerance, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.'' EPA has not found fluopyram to share a common mechanism of toxicity with any other substances, and fluopyram does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has assumed that fluopyram does not have a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see EPA's Web site at *http://www.epa.gov/pesticides/cumulative.*

D. Safety Factor for Infants and Children

1. *In general.* Section 408(b)(2)(C) of FFDCA provides that EPA shall apply an additional tenfold (10X) margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the database on toxicity and exposure unless EPA determines based on reliable data that a different margin of safety will be safe for infants and children. This additional margin of safety is commonly referred to as the FQPA Safety Factor (SF). In applying this provision, EPA either retains the default value of 10X, or uses a different additional safety factor when reliable data available to EPA support the choice of a different factor.

2. *Prenatal and postnatal sensitivity.* The available developmental toxicity studies in rats and rabbits and the multi-generation reproduction in rats demonstrate no evidence of increased susceptibility in the developing or young animals which were exposed during pre- or post-natal periods.

3. *Conclusion.* EPA has determined that reliable data show the safety of infants and children would be adequately protected if the FQPA SF were reduced to 1X. That decision is based on the following findings:

i. The toxicity database for fluopyram is complete.

ii. There is no indication that fluopyram is a neurotoxic chemical. Although transient decreases in motor and locomotor activities in the acute neurotoxicity study were seen on the day of treatment and limited use of hind-limbs and reduced motor activity was seen in the rat chronic/carcinogenicity study, there were no other associated neurobehavioral or histopathology changes found in other studies in the fluopyram toxicity database. The effects seen in the chronic/carcinogenicity study were in the presence of increased mortality and morbidity such as general pallor and emaciated appearance. Therefore, the reduced motor activity and limited use of hind-limbs seen in these two studies were judged to be the consequence of the systemic effects and not direct neurotoxicity. Additionally there is no need for a developmental neurotoxicity study or additional UFs to account for neurotoxicity.

iii. There is no evidence that fluopyram results in increased susceptibility in *in utero* rats or rabbits in the prenatal developmental studies or in young rats in the 2-generation reproduction study.

iv. There are no residual uncertainties identified in the exposure databases. The acute dietary exposure assessment was performed using conservative exposure inputs, including tolerance-level residues for all crops, whereas the chronic dietary assessment included average field-trial residue levels for all crops. The acute dietary assessment assumed 100 PCT, whereas the chronic dietary assessment utilized average percent crop treated numbers for several crops. Both acute and chronic dietary assessments incorporated empirical or default processing factors. The dietary exposure assessment also assumed that all drinking water will contain fluopyram at the highest EDWC levels modeled by the Agency for ground or surface water. Therefore, it can be concluded that the dietary exposure analysis does not underestimate risk from acute and chronic dietary exposure to fluopyram. While there is the potential for handler and post-application residential exposure, the best data and approaches currently available were used in the fluopyram residential assessment. The Agency used the current conservative approaches for residential assessment, many of which include recent upgrades to the SOPs. The Agency believes that the calculated risks represent conservative estimates of exposure because maximum application rates are used to define residue levels upon which the calculations are based. Therefore, residential exposures are unlikely to be underestimated.

E. Aggregate Risks and Determination of Safety

EPA determines whether acute and chronic dietary pesticide exposures are safe by comparing aggregate exposure estimates to the acute PAD (aPAD) and chronic PAD (cPAD). For linear cancer risks, EPA calculates the lifetime probability of acquiring cancer given the estimated aggregate exposure. Short-, intermediate-, and chronic-term risks are evaluated by comparing the estimated aggregate food, water, and residential exposure to the appropriate PODs to ensure that an adequate MOE exists.

1. *Acute risk.* Using the exposure assumptions discussed in this unit for acute exposure, the acute dietary exposure from food and water to fluopyram will occupy 35% of the aPAD for children 1–2 years old, the population group receiving the greatest exposure.

2. *Chronic risk.* Using the exposure assumptions described in this unit for chronic exposure, EPA has concluded that chronic exposure to fluopyram from food and water will utilize 81% of the cPAD for children 1–2 years old the population group receiving the greatest exposure. Based on the explanation in Unit III.C.3., regarding residential use patterns, chronic residential exposure to residues of fluopyram is not expected.

3. *Short-term risk.* Short-term aggregate exposure takes into account short-term residential exposure plus chronic exposure to food and water (considered to be a background exposure level). Fluopyram is currently registered for uses that could result in short-term residential exposure, and the Agency has determined that it is appropriate to aggregate chronic exposure through food and water with short-term residential exposures to fluopyram.

Using the exposure assumptions described in this unit for short-term exposures, EPA has concluded the combined short-term food, water, and residential exposures result in aggregate MOEs from handler inhalation exposure (the most conservative risk estimate) of 1,500 for adults. For children 1–2 years old, post-application incidental oral exposures aggregated with food and drinking water resulted in an MOE of 1,500. Because EPA's level of concern for fluopyram is a MOE of 100 or below, these MOEs are not of concern.

4. *Intermediate-term risk.* Intermediate-term aggregate exposure

takes into account intermediate-term residential exposure plus chronic exposure to food and water (considered to be a background exposure level). Intermediate-term residential exposure is not expected given the intermittent nature of applications in residential settings.

5. *Aggregate cancer risk for U.S. population.* As discussed in Unit III.A, because the Agency is regulating exposure to fluopyram at doses lower than those that may induce cellular proliferation in the liver or thyroid glands, fluopyram is not expected to pose a cancer risk to humans.

6. *Determination of safety.* Based on these risk assessments, EPA concludes that there is a reasonable certainty that no harm will result to the general population, or to infants and children from aggregate exposure to fluopyram residues.

IV. Other Considerations

A. Analytical Enforcement Methodology

The German multiresidue method DFG Method S 19, a gas chromatography with mass selective detection (GC/MSD) method, is the method for the enforcement of tolerances for fluopyram residues in/on crop commodities and a high performance liquid chromatography method with tandem mass spectrometry detection (HPLC/MS/MS), Method 01079, has been accepted for the enforcement of tolerances for residues of fluopyram and its metabolite, AE C656948-benzamide, in livestock commodities. The validated limit of quantitation (LOQ) is 0.01 ppm and the calculated limit of detection (LOD) is 0.003 ppm for each analyte in each matrix. The method was adequately validated using cattle milk, fat, muscle, liver, and kidney, and hen whole egg fortified with fluopyram and AE C656948-benzamide, each at 0.01 and 0.10 ppm. The method was subjected to ILV using samples of beef muscle, beef liver, eggs, and milk fortified with fluopyram and AE C656948-benzamide, each at 0.01 and 0.10 ppm.

Adequate enforcement methodology DFG Method S 19 and Method 01079 are available to enforce the tolerance expression.

The method may be requested from: Chief, Analytical Chemistry Branch, Environmental Science Center, 701 Mapes Rd., Ft. Meade, MD 20755–5350; telephone number: (410) 305–2905; email address: *residuemethods@epa.gov.*

B. International Residue Limits

In making its tolerance decisions, EPA seeks to harmonize U.S. tolerances with international standards whenever possible, consistent with U.S. food safety standards and agricultural practices. EPA considers the international maximum residue limits (MRLs) established by the Codex Alimentarius Commission (Codex), as required by FFDCA section 408(b)(4). The Codex Alimentarius is a joint United Nations Food and Agriculture Organization/World Health Organization food standards program, and it is recognized as an international food safety standards-setting organization in trade agreements to which the United States is a party. EPA may establish a tolerance that is different from a Codex MRL; however, FFDCA section 408(b)(4) requires that EPA explain the reasons for departing from the Codex level.

There are Codex maximum residue levels MRLs established on berries (blackberry and raspberry 3 ppm), broccoli and Brussels sprouts (0.3 ppm), dry beans (0.07 ppm), head cabbage (0.15 ppm), carrot (0.4 ppm), cauliflower (0.09 ppm), cherry (0.7 ppm), cucumber (0.5 ppm), dried grapes (currants, raisins and sultanas 5 ppm), grapes (2 ppm), leek (0.15 ppm), lettuce (head and leaf 15 ppm), onion bulb (0.07 ppm), peach subgroup (1 ppm), peanut (0.03 ppm), plums (0.5 ppm), pome fruits (0.5 ppm), potato (0.03 ppm), rapeseed (1 ppm), strawberry (0.4 ppm), sugar beet (0.04 ppm), tomato (0.4 ppm), and tree nuts (0.04 ppm).

The tolerance definitions are harmonized among the US, Canada, and Codex for all plant and livestock commodities. In addition, the U.S. tolerances for grape (within the fruit, small vine climbing, except fuzzy kiwifruit, subgroup 13–07F), peach (within the fruit, stone, peach subgroup 12–12B), and plum (within the fruit, stone, plum subgroup 12–12C) are harmonized with the Codex MRLs for grape, peach, and plum.

Harmonization with Codex MRLs for berries (blackberry and raspberry 3 ppm), broccoli and Brussels sprouts (0.3 ppm), dry beans (0.70 ppm), head cabbage (0.15 ppm), cauliflower (0.09 ppm), cherry (0.7 ppm), cucumber (0.5 ppm), leek (0.15 ppm), lettuce (head and leaf 15 ppm), onion bulb (0.07 ppm), peanut (0.03 ppm), pome fruits (0.5 ppm), potato (0.03 ppm), rapeseed (1 ppm), strawberry (0.4 ppm), sugar beet (0.04 ppm), tomato (0.4 ppm), and tree nuts (0.04 ppm) is not possible because the Codex MRLs are lower than the recommended U.S. tolerances. The U.S. tolerances cannot be harmonized because following the approved label directions could result in residues above the recommended tolerances. The U.S. tolerances for carrot and raisin are higher than the Codex MRLs. EPA is not harmonized with Codex in order to remain harmonized with Canada.

The U.S. and Codex livestock MRLs are not harmonized due to different livestock dietary burdens. Fluopyram is approved for use on more livestock feed stuffs in the United States and thus contributes to a greater portion of the assessment of the livestock dietary burden in the United States than in the assessment of livestock dietary burden supporting the Codex MRLs. Harmonization could lead to tolerance exceedances when the pesticide is used legally in the United States.

C. Revisions to Petitioned-For Tolerances

The petitioned-for tolerances differ from the tolerances that EPA is establishing for sugar beet roots, onion bulbs, leafy greens subgroup 4A, crop subgroup 6C, fruiting vegetables (8–10B), melon subgroup 9A, citrus, subgroup 13–07F, raisin, tree nuts, crop group 15, herb subgroup 19A, dill seed, and subgroup 20A.

For citrus, crop group 15, fruiting vegetables (8–10B), onion bulbs, rapeseed subgroup 20A, and tree nuts, the Organization for Economic Cooperation and Development (OECD) statistical calculation procedures applied to the field trial residue data provided a different value than the petitioned-for tolerances. Also, for crop group 15 and subgroup 20A, the values petitioner requested were based on a data set that excluded a field trial (on sorghum and canola, respectively) as an outlier based on statistical tests. However, the trials could not be excluded by the Agency since there were no abnormal field conditions.

While the petitioner requested a tolerance for crop group 15, except rice and sorghum, the Agency has determined that a crop group 15 tolerance, except corn and rice is appropriate. This is due to the wide variation in residue levels from the available data. The minimum residues on sweet corn at 0.01 ppm and the maximum residues on sorghum 3.2 ppm differ by more than 5x; therefore, the tolerance level (1.5 ppm) is not appropriate to establish a crop group tolerance with all the representative crops. Rather, based on the available data, EPA is establishing tolerances on grain, cereal, except rice and corn, group 15 at 4.0 ppm; and individual tolerance on corn, field, grain at 0.02 ppm; corn, pop, grain at 0.02 ppm; and corn, sweet, kernal plus cob with husks removed at 0.01 ppm.

Although the petitioner requested two separate tolerances for commodities of subgroup 4A, the available data support a tolerance of 40 ppm for residues of fluopyram in/on leafy greens subgroup 4A and at 20 ppm on leaf petioles subgroup 4B.

The petitioner requested two separate tolerances for herb subgroup 19A, fresh and herbs, dried. Because subgroup 19A covers both dried and fresh herbs, the Agency is establishing a tolerance on herb subgroup 19A at 40 ppm, based on available data.

The petitioner has requested to establish tolerances on vegetables, legume; dried beans and peas, except soybeans (subgroup 6C) at 0.70 ppm. Because only data on dried beans is available, there is not sufficient data to support establishing a subgroup tolerance. Therefore, based on the available residue data for dried beans, the Agency is establishing an individual tolerance of 0.70 ppm on dried beans only. EPA is establishing dry bean tolerance at 0.70 ppm to harmonize with Canada.

The petitioner had requested to establish tolerances on vegetables, cucurbit, cucumber/squash subgroup at 0.30 ppm and fruit, pome at 1.0 ppm. Based on available data that reflect the proposed use pattern, EPA is establishing a tolerance on squash/cucumber subgroup 9B at 0.60 ppm and fruit, pome, group 11–10 at 0.80 ppm.

For harmonization purposes with Canada, tolerances being established for sugar beet, melon subgroup 9A, tree nuts, and subgroup 13–07F are slightly increased above the tolerance levels requested for those commodities.

The requested grape, raisin tolerance of 4.0 ppm is being reduced to 3.0 ppm based on the highest average field trial (HAFT) (0.948 ppm) for grape and processing factor of 2.4.

Because use of fluopyram is limited to Region 3 (Florida), the Agency is establishing a tolerance with a regional registration for inadvertent or indirect residues of fluopyram on sugarcane, cane (0.08 ppm) when sugarcane is used as a rotational crop.

The requested tolerances for livestock commodities were based on some livestock feed stuffs that have been withdrawn from the list of crops to be treated with fluopyram. Based on a recalculation of the livestock dietary burden, the Agency is establishing tolerances for livestock commodities that are lower than requested.

In addition, the Agency has revised several commodity terms to reflect the current commodity definitions used by the Agency and revised several tolerance level values to be consistent with EPA's practice of extending tolerance values out to two significant figures.

Although the petition requested a tolerance for nut tree group 14, the Agency is establishing a tolerance for nut, tree 14–12 consistent with its stated policy of not establishing tolerances for pre-existing crop groups. *See* 77 FR 50617, 50619 (Aug. 22, 2012).

Finally, the requests for tolerances were withdrawn for the following commodities: Crop group 7 at 90.0 ppm; crop group 17 at 80.0 ppm; peanut hay at 40.0 ppm, soybean forage at 9.0 ppm; and soybean hay at 30.0 ppm. A separate tolerance for wheat, milled byproducts is not needed as it is covered by the crop group 15 tolerance.

V. Conclusion

Therefore, tolerances are established for residues of fluopyram in or on almond, hulls at 10 ppm; artichoke, globe at 4.0 ppm, bean, dry at 0.70 ppm; beet, sugar at 0.10 ppm; berry, low growing, except cranberry, subgroup 13–07G at 2.0 ppm; brassica, head and stem, subgroup 5A at 4.0 ppm; brassica, leafy greens, subgroup 5B at 50 ppm; bushberry subgroup 13–07B at 7.0 ppm; grain, aspirated grain fractions at 50 ppm; caneberry subgroup 13–07A at 5.0 ppm; cereal, forage, fodder and straw, group 16 at 20 ppm; cherry subgroup 12–12A at 2.0 ppm; citrus, oil at 8.0 ppm; corn, field, grain at 0.02 ppm; corn, pop, grain at 0.02 ppm; corn, sweet, kernel plus cob with husks removed 0.01 ppm; cotton, gin byproducts at 30 ppm; cottonseed subgroup 20C at 0.80 ppm; dill, seed at 70 ppm; rapeseed subgroup 20A at 5.0 ppm; fruit, citrus, group 10–10 at 1.0 ppm; fruit, pome, group 11–10 at 0.80 ppm; fruit, small vine climbing, except fuzzy kiwifruit, subgroup 13–07F at 2.0 ppm; grape, raisin at 3.0 ppm; grain, cereal, group 15, except corn and rice at 4.0 ppm; grain, herb subgroup 19A at 40 ppm; hop, dried cones at 60 ppm; leaf petioles subgroup 4B at 20 ppm; leafy greens subgroup 4A at 40 ppm; melon subgroup 9A at 1.0 ppm; nut, tree, group 14–12 at 0.05 ppm; onion, bulb, subgroup 3–07A at 0.40 ppm; onion, green, subgroup 3–07B at 15 ppm; pea and bean, succulent shelled, subgroup 6B at 0.20 ppm; peach subgroup 12–12B at 1.0 ppm; peanut at 0.20 ppm; potato, wet peel at 0.30 ppm; pepper/eggplant subgroup 8–10B at 4.0 ppm; plum subgroup 12–12C at 0.50 ppm; soybean, seed at 0.30 ppm; squash/cucumber subgroup 9B at 0.60 ppm; sunflower subgroup 20B at 0.70 ppm; tomato subgroup 8–10A at 1.0 ppm; vegetable, leaves of root and tuber, group 2 at 30 ppm; vegetable, legume, edible podded, subgroup 6A at 4.0 ppm; vegetable, root, except sugar beet, subgroup 1B at 0.30 ppm; and vegetable, tuberous and corm, subgroup 1C at 0.10 ppm.

Tolerances are also established for residues of fluopyram and its metabolite 2-(trifluoromethyl)benzamide, expressed in parent equivalents for cattle, fat at 0.70 ppm; cattle, meat at 0.80 ppm; cattle, meat byproducts at 7.5 ppm; egg at 0.08 ppm; goat, fat at 0.70 ppm; goat, meat at 0.80 ppm; goat, meat byproducts at 7.5 ppm; hog, meat byproducts at 0.20 ppm; horse, fat at 0.70 ppm; horse, meat at 0.80 ppm; horse, meat byproducts at 7.5 ppm; milk at 0.40 ppm; poultry, fat at 0.04 ppm; poultry, meat at 0.04 ppm; poultry, meat byproducts at 0.16 ppm; sheep, fat at 0.70 ppm; sheep, meat at 0.80 ppm; and sheep, meat byproducts at 7.5 ppm.

In addition, the Agency is removing tolerances for almond, hull; apple, wet pomace; bean, dry; beet, sugar, root; canola seed; cotton, gin byproducts; cotton, undelinted seed; cherry; grape, wine; grain, cereal, except rice, group 15; grain, cereal, forage, fodder, and straw, group 16; nut, tree, group 14; peanut; pistachio; potato; soybean forage; soybean hay; soybean, seed; strawberry; and watermelon because they are superseded by other tolerances being established in this action.

VI. Statutory and Executive Order Reviews

This action establishes tolerances under FFDCA section 408(d) in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled ''Regulatory Planning and Review'' (58 FR 51735, October 4, 1993). Because this action has been exempted from review under Executive Order 12866, this action is not subject to Executive Order 13211, entitled ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001) or Executive Order 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997). This action does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), nor does it require any special considerations under Executive Order 12898, entitled ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations'' (59 FR 7629, February 16, 1994).

Since tolerances and exemptions that are established on the basis of a petition under FFDCA section 408(d), such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), do not apply.

This action directly regulates growers, food processors, food handlers, and food retailers, not States or tribes, nor does this action alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4). As such, the Agency has determined that this action will not have a substantial direct effect on States or tribal governments, on the relationship between the national government and the States or tribal governments, or on the distribution of power and responsibilities among the various levels of government or between the Federal Government and Indian tribes. Thus, the Agency has determined that Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999) and Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 9, 2000) do not apply to this action. In addition, this action does not impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note).

VII. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: March 1, 2016.

G. Jeffery Herndon,

Acting Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

■ 1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

■ 2. Section 180.661 is revised to read as follows:

§ 180.661 Fluopyram; tolerances for residues.

(a) *General.* (1) Tolerances are established for residues of the fungicide Fluopyram, *N*-[2-[3-chloro-5-(trifluoromethyl)-2-pyridinyl]ethyl]-2-(trifluoromethyl)benzamide, including its metabolites and degradates in or on the commodities in the table below. Compliance with the tolerance levels specified in the table is to be determined by measuring only fluopyram in or on the commodity.

Commodity	Parts per million
Almond, hulls	10
Artichoke, globe	4.0
Banana [1]	1.0
Bean, dry	0.70
Beet, sugar	0.10
Berry, low growing, except cranberry, subgroup 13–07G	2.0
Brassica, head and stem, subgroup 5A	4.0
Brassica, leafy greens, subgroup 5B	50
Bushberry subgroup 13–07B	7.0
Caneberry subgroup 13–07A	5.0
Cherry subgroup 12–12A	2.0
Citrus, oil	8.0
Corn, field, grain	0.02
Corn, pop, grain	0.02
Corn, sweet, kernel plus cob with husks removed	0.01
Cotton, gin byproducts	30
Cottonseed subgroup 20C	0.80
Dill, seed	70
Fruit, citrus, group 10–10	1.0
Fruit, pome, group 11–10	0.80
Fruit, small vine climbing, except fuzzy kiwifruit, subgroup 13–07F	2.0
Grain, aspirated grain fractions	50
Grain, cereal, forage, fodder and straw, group 16	20
Grain, cereal, group 15, except corn and rice	4.0
Grape, raisin	3.0
Herb subgroup 19A	40
Hop, dried cones	60
Leafy greens subgroup 4A	40
Leafy petioles subgroup 4B	20
Melon subgroup 9A	1.0
Nut, tree, group 14–12	0.05
Onion, bulb, subgroup 3–07A	0.40
Onion, green, subgroup 3–07B	15
Pea and bean, succulent shelled, subgroup 6B	0.20
Peach subgroup 12–12B	1.0
Peanut	0.20
Pepper/eggplant subgroup 8–10B	4.0
Plum subgroup 12–12C	0.50
Potato, wet peel	0.30
Rapeseed subgroup 20A	5.0
Soybean, seed	0.30
Squash/cucumber subgroup 9B	0.60
Sunflower subgroup 20B	0.70
Tomato subgroup 8–10A	1.0
Vegetable, leaves of root and tuber, group 2	30
Vegetable, legume, edible podded, subgroup 6A	4.0
Vegetable, root, except sugar beet, subgroup 1B	0.30
Vegetable, tuberous and corm, subgroup 1C	0.10

[1] There are no U.S. registrations.

(2) Tolerances are established for residues of the fungicide fluopyram, *N*-[2-[3-chloro-5-(trifluoromethyl)-2-pyridinyl]ethyl]-2-(trifluoromethyl)benzamide, including its metabolites and degradates. Compliance with the tolerance levels specified in the table below is to be determined by measuring only the sum of fluopyram and its metabolite, 2-(trifluoromethyl)benzamide, calculated as the stoichiometric equivalent of fluopyram, in or on the commodity.

Commodity	Parts per million
Cattle, fat	0.70
Cattle, meat	0.80
Cattle, meat byproducts	7.5
Egg	0.08
Goat, fat	0.70
Goat, meat	0.80
Goat, meat byproducts	7.5
Hog, fat	0.20
Hog, meat	0.02
Hog, meat byproducts	0.20
Horse, fat	0.70
Horse, meat	0.80
Horse, meat byproducts	7.5
Milk	0.40
Poultry, fat	0.04
Poultry, meat	0.04
Poultry, meat byproducts	0.20
Sheep, fat	0.70
Sheep, meat	0.80
Sheep, meat byproducts	7.5

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* Tolerances with regional registration, as defined in § 180.1(1), are established for indirect or inadvertent residues of fungicide fluopyram, N-[2-[3-chloro-5-(trifluoromethyl)-2-pyridinyl]ethyl]-2-(trifluoromethyl)benzamide, including

its metabolites and degradates, in or on the commodities in the table below. Compliance with the tolerance levels specified in the table is to be determined by measuring only fluopyram in or on the commodity.

Commodity	Parts per million
Sugarcane, cane	0.08

(d) *Indirect or inadvertent residues.* It is recommended that tolerances be established for indirect or inadvertent residues of fungicide fluopyram, *N*-[2-[3-chloro-5-(trifluoromethyl)-2-pyridinyl]ethyl]-2-(trifluoromethyl)benzamide, including its metabolites and degradates, in or on the commodities in the table below. Compliance with the tolerance levels specified in the table is to be determined by measuring only fluopyram in or on the commodity.

Commodity	Parts per million
Alfalfa, forage	0.45
Alfalfa, hay	1.1
Soybean, seed	0.10

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BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 425, and 495

[CMS–1631–F2]

RIN 0938–AS40

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Corrections

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correcting amendment.

SUMMARY: This document corrects technical and typographical errors that appeared in the final rule with comment period published in the November 16, 2015 **Federal Register** (80 FR 70886 through 71386) entitled ''Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016.''

DATES: *Effective date:* This correcting document is effective March 7, 2016.

Applicability date: The corrections indicated in this document are applicable beginning January 1, 2016.

FOR FURTHER INFORMATION CONTACT: Lisa Ohrin Wilson (410) 786–8852, or Matthew Edgar (410) 786–0698, for issues related to physician self-referral updates. Jessica Bruton, (410) 786–5991 for all other issues.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2015–28005 (80 FR 70886 through 71386), the final rule entitled ''Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016'' (hereinafter referred to as the CY 2016 PFS final rule with comment period), there were a number of technical and typographical errors that are identified and corrected in section IV., the Correction of Errors. The effective date for the rule was January 1, 2016, except for the definition of ''ownership or investment interest'' in § 411.362(a), which has an effective date of January 1, 2017. These corrections are applicable as of January 1, 2016. We note that Addenda B and C to the CY 2016 PFS final rule with comment period as corrected by this correcting amendment are available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

II. Summary of Errors

A. Summary of Errors in the Preamble

On page 70894, we inadvertently omitted a sentence from the first comment summary regarding applying the same overrides used for the MP RVU calculations to the PE calculations.

On page 70894, we inadvertently omitted a clause from the response summary regarding the overrides that also apply to the MP RVU calculation in the development of PE RVUs.

On page 70898, due to data errors made in the ratesetting process, many of the values contained in Table 4: Calculation of PE RVUs under Methodology for Selected Codes, are incorrect.

On page 70953, we inadvertently included language regarding the application of the equipment utilization assumption.

On page 70971,

a. Due to a typographical error, the work RVU for CPT code 76945 was listed incorrectly. As a result, the work RVU for CPT code 76948 was also inadvertently listed incorrectly.

b. Due to a typographical error, we inadvertently referred to CPT code 76948 rather than CPT code 76945.

On page 70992, due to a typographical error in Table 13—CY 2016 Actions on Codes with CY 2015 Interim Final RVUs, the CY 2016 work RVU for CPT code 76948 was incorrectly displayed.

On page 71317, we inadvertently included language in our comment discussion on the issue regarding compensation arrangements.

On page 71357,

a. Due to data errors, we incorrectly stated the estimated CY 2016 net reduction in expenditures.

b. Due to data errors, we incorrectly stated the reduction to the conversion factor.

c. Due to data errors, we incorrectly stated the CY 2016 PFS conversion factors. As a result, many of the values in Table 60—Calculation of the CY 2016 PFS Conversion Factor, are incorrect.

d. Due to data errors, we incorrectly stated the CY 2016 PFS anesthesia conversion factors. As a result, many of the values in Table 61—Calculation of the CY 2016 PFS Anesthesia Conversion Factor, are incorrect.

On pages 71358 through 71359, due to data errors, many of the values in Table 62—CY 2016 PFS Estimated Impact On Total Allowed Charges By Specialty, are incorrect.

On pages 71359 through 71360, due to data errors, many of the values in Table 63— Impact on CY 2016 Payment for Selected Procedures, are incorrect.

On page 71369,

a. Due to data errors, we incorrectly stated the CY 2016 national payment amount in the nonfacility setting for CPT code 99203.

b. Due to data errors, we incorrectly stated the CY 2016 proposed beneficiary coinsurance for CPT code 99203.

B. Summary of Errors in Regulation Text

On page 71375 of the CY 2016 PFS final rule with comment period, we made a typographical error in § 411.357(d)(1)(iv). In this paragraph, we inadvertently included the word ''for''.

On page 71377 of the CY 2016 PFS final rule with comment period, we made a typographical error in § 411.357(x)(1)(vi)(A). In this paragraph, we inadvertently omitted the word ''directly''.

C. Summary and Correction of Errors in the Addenda on the CMS Web site

Due to the errors identified and summarized in section II.A and B of this document, we are correcting errors in the work, PE or MP RVUs (or combinations of these RVUs) in Addendum B: CY 2016 Relative Value Units (RVUs) And Related Information Used In Determining Final Medicare Payments and Addendum C: CY 2016

Interim Final Relative Value Units (RVUs). We note that corrections to the RVUs for codes with identified errors affect additional codes due to the budget neutrality and relativity of the PFS. These errors are corrected in the revised Addenda B and C available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

In addition to the errors identified in section II.A. of this document, the following errors occur in the addenda.

Due to a technical error in the development of PE RVUs, the PE RVUS displayed in Addenda B and C were incorrect. In constructing the algorithm used to adjust specialty-specific volume for individual codes as described on page 70895 of the CY 2016 PFS final rule, claims volumes for codes billed with payment modifiers with different adjustments for payment and time were erroneously adjusted based on the time-based adjustment factor, not the payment-based factor. As a result, payment-adjusted volume associated with those modifiers for which the time-based adjustment factor is different from the payment-based adjustment factor was inaccurate and has been corrected. The direct impact of the errors were limited to the practice expense for services frequently reported with payment modifiers with different adjustments for payment and time. However, the PE RVUs for many more codes may have been affected indirectly due to BN adjustments. The two specialties that report services paid under the anesthesia fee schedule were the only specialties significantly affected by the change. The PE RVUs that result from the correction of this error are reflected in the corrected Addendum B (and Addendum C, if applicable) available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

Due to an error in the algorithm that we used to identify services that were subject to the phase-in of significant RVU reductions, CPT codes 67108, 67113, 67227 and 67228 were not included on the list of codes subject to the phase-in. These errors are corrected in the revised Codes Subject to Phase-in file available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/,* and the resulting changes to the RVUs are reflected in the corrected Addenda B and C, available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

Due to a data error, the useful life for the equipment item ''FibroScan'' (ER101) was incorrect in the direct PE input database. This error is corrected in the revised Direct PE Input Database available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*. As a result of this error being corrected, changes to PE RVUs are reflected in the corrected Addenda B and C, available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

Due to a data error, the incorrect CY 2016 global periods were included in Addendum B (and Addendum C, if applicable) for the following CPT codes: 20240, 43210, 61650, 67227, 67228, 73060, and 73560. The corrected CY 2016 global periods for these codes are reflected in the corrected Addendum B (and Addendum C, if applicable) available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

Due to an inadvertent error, the CY 2016 work RVUs for HCPCS codes G0296 and G0297 were incorrectly displayed in Addendum B. The correct CY 2016 work RVUS for these codes are reflected in the corrected Addendum B available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

Due to a technical error, the clinical labor times associated with CPT codes 31654, 88333 and 99416 were inadvertently omitted from the direct PE input database. This error is corrected in the revised direct PE input database available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*. The PE RVUs that result from the correction of this error are reflected in the corrected Addendum B available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

Due to a data input omission, the RVUs that reflect the appropriate payment rates for the treatment of intensive cardiac rehabilitation, as specified under section 1848(b)(5) of the Social Security Act (the Act), were not included in Addendum B. The appropriate RVUs for intensive cardiac rehabilitation are reflected in the corrected Addendum B available on the CMS Web site at *http://www.cms.gov//PhysicianFeeSched/*.

III. Waiver of Proposed Rulemaking

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA, and section 1871(e)(1)(B)(i) of the Act mandate a 30-day delay in effective date after issuance or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the APA notice and comment, and delay in effective date requirements; similarly, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice and comment, and delay in effective date requirements of the Act. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal notice and comment rulemaking procedures for good cause if the agency makes a finding that the notice and comment process is impracticable, unnecessary, or contrary to the public interest; and includes a statement of the finding and the reasons for it in the notice. In addition, both section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and the agency includes in the rule a statement of the finding and the reasons for it.

In our view, this correcting document does not constitute a rulemaking that would be subject to these requirements. This document merely corrects typographical and technical errors in the CY 2016 PFS final rule with comment period and the corresponding addenda posted on the CMS Web site. The corrections contained in this document are consistent with, and do not make substantive changes to, the policies and payment methodologies that were adopted subject to notice and comment procedures in the CY 2016 PFS final rule with comment period. As a result, the corrections made through this correcting document are intended to ensure that the CY 2016 PFS final rule with comment period accurately reflects the policies adopted in that rule.

Even if this were a rulemaking to which the notice and comment and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the CY 2016 PFS final rule with comment period or delaying the effective date of the corrections would be contrary to the public interest because it is in the public interest to ensure that the CY 2016 PFS final rule with comment period accurately reflects our final policies as soon as possible following the date they take effect. Further, such procedures would be unnecessary, because we are not altering the payment methodologies or policies, but rather, we are simply correcting the **Federal Register** document to reflect the policies that we previously proposed, received comment on, and subsequently

finalized. This correcting document is intended solely to ensure that the CY 2016 PFS final rule with comment period accurately reflects these policies. For these reasons, we believe there is good cause to waive the requirements for notice and comment and delay in effective date.

Correction of Errors

In FR Doc. 2015–28005 of November 16, 2015 (80 FR 70886), make the following corrections:

A. Correction of Errors in the Preamble

1. On page 70894, first column,

a. First full paragraph, line 9, is corrected by adding the sentence ''One commenter suggested that for CY 2016 we apply the same overrides used for the MP RVU calculations to the PE calculations.''.

b. Second full paragraph, lines 21 through 27, the sentence ''Therefore, we are finalizing the policy as proposed for CY 2016 but will seek comment on the proposed CY 2017 PFS rates and whether or not the incorporation a new year of utilization data mitigates the need for service-level overrides.'' is corrected to read ''Therefore, we are finalizing the policy as proposed for CY 2016 and only apply the overrides that also apply to the MP RVU calculation in the development of PE RVUs but will seek comment on the proposed CY 2017 PFS rates and whether or not the incorporation of a new year of utilization data mitigates the need for service-level overrides.''.

2. On page 70898, Table 4–Calculation of PE RVUs under Methodology for Selected Codes, the table is corrected to read as follows:

BILLING CODE 4120–01–P

	Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single Facility	71020 Chest x-ray Nonfacility	71020-TC Chest x-ray, Nonfacility	71020-26 Chest x-ray, Nonfacility	93000 ECG, complete, Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
(1) Labor cost (Lab)	Step 1	AMA		13.32	77.52	5.74	5.74	0	5.1	5.1	0
(2) Supply cost (Sup)	Step 1	AMA		2.98	7.34	0.53	0.53	0	1.19	1.19	0
(3) Equipment cost (Eqp)	Step 1	AMA		0.17	0.58	7.08	7.08	0	0.09	0.09	0
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	16.48	85.45	13.36	13.36	0	6.38	6.38	0
(5) Direct adjustment (Dir. Adj.)	Steps 2-4	See Footnote*		0.5957	0.5957	0.5957	0.5957	0.5957	0.5957	0.5957	0.5957
(6) Adjusted Labor	Steps 2-4		=(1)*(5)	7.93	46.18	3.42	3.42	0	3.04	3.04	0
(7) Adjusted Supplies	Steps 2-4	=Eqp * Dir Adj	=(2)*(5)	1.78	4.37	0.32	0.32	0	0.71	0.71	0
(8) Adjusted Equipment	Steps 2-4	=Sup * Dir Adj	=(3)*(5)	0.1	0.35	4.22	4.22	0	0.05	0.05	0
(9) Adjusted Direct	Steps 2-4		=(6)+(7)+(8)	9.81	50.9	7.96	7.96	0	3.8	3.8	0
(10) Conversion Factor (CF)	Step 5	PFS		35.9335	35.9335	35.9335	35.9335	35.9335	35.9335	35.9335	35.9335
(11) Adj. labor cost converted	Step 5	=(Lab * Dir Adj)/CF	=(6)/(10)	0.22	1.29	0.1	0.1	0	0.08	0.08	0
(12) Adj. supply cost converted	Step 5	=(Sup * Dir Adj) /CF	=(7)/(10)	0.05	0.12	0.01	0.01	0	0.02	0.02	0
(13) Adj. equipment cost converted	Step 5	=(Eqp * Dir Adj)/ CF	=(8)/(10)	0	0.01	0.12	0.12	0	0	0	0
(14) Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.27	1.42	0.22	0.22	0	0.11	0.11	0
(15) Work RVU	Setup File	PFS		0.97	33.75	0.22	0	0.22	0.17	0	0.17
(16) Dir_pct	Steps 6,7	Surveys		0.25	0.17	0.29	0.29	0.29	0.29	0.29	0.29
(17) Ind_pct	Steps 6,7	Surveys		0.75	0.83	0.71	0.71	0.71	0.71	0.71	0.71
(18) Ind. Alloc. Formula (1st part)	Step 8	See Step 8		14/(16)*(17)	14/(16)*(17)	14/(16)*(17)	14/(16)*(17)	14/(16)*(17)	14/(16)*(17)	14/(16)*(17)	14/(16)*(17)
(19) Ind. Alloc.(1st part)	Step 8		See 18	0.83	6.71	0.54	0.54	0	0.26	0.26	0
(20) Ind. Alloc. Formula (2nd pt)	Step 8	See Step 8		(15)	(15)	(15+11)	(11)	(15)	(15+11)	(11)	(15)
(21) Ind. Alloc.(2nd part)	Step 8		See 20	0.97	33.75	0.32	0.1	0.22	0.25	0.08	0.17
(22) Indirect Allocator (1st + 2nd)	Step 8		=(19)+(21)	1.8	40.46	0.85	0.63	0.22	0.52	0.35	0.17
(23) Indirect Adjustment (Ind Adj)	Steps 9-11	See Footnote**		0.3816	0.3816	0.3816	0.3816	0.3816	0.3816	0.3816	0.3816
(24) Adjusted Indirect Allocator	Steps 9-11	=Ind Alloc * Ind Adj		0.69	15.44	0.33	0.24	0.08	0.2	0.13	0.06
(25) Ind. Practice Cost Index (IPCI)	Steps 12-16			1.07	0.75	0.99	0.99	0.99	0.91	0.91	0.91
(26) Adjusted Indirect	Step 17	= Adj.Ind Alloc * PCI	=(24)*(25)	0.74	11.55	0.32	0.24	0.08	0.18	0.12	0.06
(27) Final PE RVU	Step 18	=(Adj Dir + Adj Ind) * Other Adj	=((14)+(26)) * Other Adj)	1.01	12.97	0.54	0.46	0.08	0.29	0.23	0.06

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Notes: PE RVUs above (row 27), may not match Addendum B due to rounding.
The use of any particular conversion factor (CF) in table to illustrate the PE Calculation has no effect on the resulting RVUs.
*The direct adj = [current pe rvus * CF * avg dir pct]/[sum direct inputs] = [step2]/[step3]; **The indirect adj =[current pe rvus * avg ind pct]/[sum of ind allocators]=[step9]/[step10]

BILLING CODE 4120–01–C

3. On page 70953, second column, first partial paragraph, lines 3 through 6, the sentence ''This approach is consistent with the application of the equipment utilization assumption for advanced diagnostic imaging'' is deleted.

4. On page 70971,

a. First column, first full paragraph, line 15, the phrase ''work RVU of 0.56'' is corrected to read ''work RVU of 0.67''.

b. First column, third full paragraph, line 12, the CPT code ''76945'' is corrected to read ''76948''.

c. First column, fourth full paragraph, line 4 the CPT code ''76945'' is corrected to read ''76948''.

d. First column, fourth full paragraph, line 16 the CPT code ''76945'' is corrected to read ''76948''.

5. On page 70992, in Table 13—CY 2016 Actions on Codes with CY 2015 Interim Final RVUs, bottom half of the page, in columns 3 and 4, the work RVU ''0.38'' for CPT code 76948 is corrected to read ''0.67''.

6. On page 71317,

a. Third column, second full paragraph, line 2, the phrase ''on this issue (38, 50, 68, 73, 80)'' is corrected to read ''on this issue''.

b. Third column, second full paragraph, line 10, the phrase ''Another commenter (38)'' is corrected to read ''Another commenter''.

7. On page 71357,

a. Third column, first partial paragraph, line 13, the figure ''0.23'' is corrected to read ''0.22''.

b. Third column, first partial paragraph, line 24, the figure ''–0.77'' is corrected to read ''−0.78.''

c. Third column, first full paragraph, line 9, the figure ''$35.8279'' is corrected to read ''$35.8043''.

d. Third column, first full paragraph, line 17, the figure ''$22.3309'' is corrected to read ''$21.9935''.

e. Table 60—Calculation of the CY 2016 PFS Conversion Factor, the table is corrected to read as follows:

Conversion Factor in effect in CY 2015		35.9335
Update Factor	0.5 percent (1.005)	
CY 2016 RVU Budget Neutrality Adjustment	−0.076 percent (0.99924)	
CY 2016 Target Recapture Amount	−0.78 percent (0.9922)	
CY 2016 Conversion Factor		35.8043

f. Table 61—Calculation of the CY 2016 Anesthesia Conversion, the table is corrected to read as follows:

CY 2015 National Average Anesthesia Conversion Factor		22.6093
Update Factor	0.5 percent (1.005)	
CY 2016 RVU Budget Neutrality Adjustment	−0.076 percent (0.99924)	
CY 2016 Anesthesia Fee Schedule Practice Expense Adjustment.	−2.372 percent (0.97628)	
CY 2016 Anesthesia Fee Schedule Malpractice Adjustment	−0.78 percent (0.9922)	
CY 2016 Target Recapture Amount	−0.78 percent (0.9922)	
CY 2016 Conversion Factor		21.9935

8. On pages 71358 through 71359, Table 62—CY 2016 PFS Estimated Impact On Total Allowed Charges By Specialty, the table is corrected to read as follows:

(A) Specialty	(B) Allowed charges (mil)	(C) Impact of work RVU changes (percent)	(D) Impact of PE RVU changes (percent)	(E) Impact of MP RVU changes (percent)	(F) Combined impact** (percent)
TOTAL	$89,020	0	0	0	0
ALLERGY/IMMUNOLOGY	221	0	1	0	1
ANESTHESIOLOGY	1,970	0	0	−2	−2
AUDIOLOGIST	61	0	−1	1	0
CARDIAC SURGERY	343	0	0	0	0
CARDIOLOGY	6,498	0	0	0	0
CHIROPRACTOR	789	0	0	0	0
CLINICAL PSYCHOLOGIST	720	0	0	0	0
CLINICAL SOCIAL WORKER	558	0	0	0	0
COLON AND RECTAL SURGERY	161	−1	0	0	−1
CRITICAL CARE	296	0	0	0	0
DERMATOLOGY	3,217	0	0	0	1
DIAGNOSTIC TESTING FACILITY	725	0	0	0	0
EMERGENCY MEDICINE	3,120	0	0	0	0
ENDOCRINOLOGY	454	0	0	0	0
FAMILY PRACTICE	6,089	0	0	0	0
GASTROENTEROLOGY	1,843	−2	−1	−1	−4
GENERAL PRACTICE	478	0	0	0	0
GENERAL SURGERY	2,210	0	0	0	0
GERIATRICS	216	0	0	0	0
HAND SURGERY	169	0	0	0	0
HEMATOLOGY/ONCOLOGY	1,788	0	0	0	0
INDEPENDENT LABORATORY	834	1	8	0	9
INFECTIOUS DISEASE	660	0	0	0	0
INTERNAL MEDICINE	11,058	0	0	0	0
INTERVENTIONAL PAIN MGMT	720	0	0	0	0
INTERVENTIONAL RADIOLOGY	298	0	0	0	1
MULTISPECIALTY CLINIC/OTHER PHYS	96	0	0	0	0
NEPHROLOGY	2,199	0	0	0	0

(A) Specialty	(B) Allowed charges (mil)	(C) Impact of work RVU changes (percent)	(D) Impact of PE RVU changes (percent)	(E) Impact of MP RVU changes (percent)	(F) Combined impact ** (percent)
NEUROLOGY	1,524	0	0	0	0
NEUROSURGERY	776	0	0	0	0
NUCLEAR MEDICINE	46	0	0	0	−1
NURSE ANES/ANES ASST	1,187	0	0	−2	−2
NURSE PRACTITIONER	2,551	0	0	0	0
OBSTETRICS/GYNECOLOGY	669	0	0	0	0
OPHTHALMOLOGY	5,506	0	0	0	−1
OPTOMETRY	1,178	0	0	0	0
ORAL/MAXILLOFACIAL SURGERY	47	0	0	0	0
ORTHOPEDIC SURGERY	3,672	0	0	0	0
OTHER	25	0	0	0	0
OTOLARNGOLOGY	1,197	0	0	0	0
PATHOLOGY	1,330	4	4	0	8
PEDIATRICS	59	0	0	0	0
PHYSICAL MEDICINE	1,035	0	0	0	0
PHYSICAL/OCCUPATIONAL THERAPY	3,102	0	0	0	0
PHYSICIAN ASSISTANT	1,728	0	0	0	0
PLASTIC SURGERY	376	0	0	0	0
PODIATRY	1,999	0	0	0	0
PORTABLE X–RAY SUPPLIER	106	0	1	0	1
PSYCHIATRY	1,317	0	0	0	0
PULMONARY DISEASE	1,780	0	0	0	0
RADIATION ONCOLOGY	1,776	0	−2	0	−2
RADIATION THERAPY CENTERS	52	0	−1	0	−1
RADIOLOGY	4,494	0	0	0	0
RHEUMATOLOGY	536	0	0	0	0
THORACIC SURGERY	350	0	0	0	0
UROLOGY	1,796	0	0	0	0
VASCULAR SURGERY	1,019	0	−1	0	−1

** Column F may not equal the sum of columns C, D, and E due to rounding.

9. On pages 71359 through 71360, Table 63—Impact on CY 2016 Payment for Selected Procedures, the table is corrected to read as follows:

CPT/HCPCS [1]	MOD	Short descriptor	Facility			Non facility		
			CY 2015 [2]	CY 2016 [3]	% Change	CY 2015 [2]	CY 2016 [3]	% Change
11721		Debride nail 6 or more	$25.15	$25.42	1	$45.28	$45.47	0
17000		Destruct premalg lesion	53.90	54.42	1	67.20	67.67	1
27130		Total hip arthroplasty	1,407.87	1,400.66	−1	NA	NA	NA
27244		Treat thigh fracture	1,277.80	1,271.05	−1	NA	NA	NA
27447		Total knee arthroplasty	1,407.52	1,400.31	−1	NA	NA	NA
33533		Cabg arterial single	1,952.63	1,947.04	0	NA	NA	NA
35301		Rechanneling of artery	1,203.41	1,199.44	0	NA	NA	NA
43239		Egd biopsy single/multiple	154.15	151.45	−2	412.52	403.87	−2
66821		After cataract laser surgery	316.21	315.44	0	334.90	334.05	0
66984		Cataract surg w/iol 1 stage	650.40	648.42	0	NA	NA	NA
67210		Treatment of retinal lesion	508.82	507.35	0	526.79	524.89	0
71010		Chest x-ray 1 view frontal	NA	NA	NA	22.64	22.56	0
71010	26	Chest x-ray 1 view frontal	9.34	9.31	0	9.34	9.31	0
77056		Mammogram both breasts	NA	NA	NA	116.42	116.01	0
77056	26	Mammogram both breasts	44.56	44.40	0	44.56	44.40	0
77057		Mammogram screening	NA	NA	NA	83.01	82.71	0
77057	26	Mammogram screening	35.93	35.80	0	35.93	35.80	0
77427		Radiation tx management x5	187.57	187.61	0	187.57	187.61	0
88305	26	Tissue exam by pathologist	39.17	39.74	1	39.17	39.74	1
90935		Hemodialysis one evaluation	73.66	73.40	0	NA	NA	NA
92012		Eye exam establish patient	53.18	53.35	0	86.24	85.93	0
92014		Eye exam&tx estab pt 1/>vst	80.85	80.92	0	124.69	124.60	0
93000		Electrocardiogram complete	NA	NA	NA	17.25	17.19	0
93010		Electrocardiogram report	8.62	8.59	0	8.62	8.59	0
93015		Cardiovascular stress test	NA	NA	NA	77.26	76.98	0
93307	26	Tte w/o doppler complete	45.99	45.83	0	45.99	45.83	0
93458	26	L hrt artery/ventricle angio	323.76	323.31	0	323.76	323.31	0
98941		Chiropract manj 3–4 regions	35.21	35.09	0	41.32	41.17	0
99203		Office/outpatient visit new	77.98	77.70	0	109.60	108.85	−1

CPT/HCPCS [1]	MOD	Short descriptor	Facility			Non facility		
			CY 2015 [2]	CY 2016 [3]	% Change	CY 2015 [2]	CY 2016 [3]	% Change
99213		Office/outpatient visit est	51.38	51.56	0	73.30	73.40	0
99214		Office/outpatient visit est	79.41	79.13	0	108.88	108.13	−1
99222		Initial hospital care	139.06	138.20	−1	NA	NA	NA
99223		Initial hospital care	205.90	204.44	−1	NA	NA	NA
99231		Subsequent hospital care	39.53	39.74	1	NA	NA	NA
99232		Subsequent hospital care	73.30	72.68	−1	NA	NA	NA
99233		Subsequent hospital care	105.64	104.91	−1	NA	NA	NA
99236		Observ/hosp same date	220.99	219.48	−1	NA	NA	NA
99239		Hospital discharge day	108.88	108.13	−1	NA	NA	NA
99283		Emergency dept visit	62.88	62.66	0	NA	NA	NA
99284		Emergency dept visit	119.66	118.87	−1	NA	NA	NA
99291		Critical care first hour	227.46	225.93	−1	279.20	277.48	−1
99292		Critical care addl 30 min	113.55	113.14	0	124.33	123.88	0
99348		Home visit est patient	NA	NA	NA	84.80	84.86	0
99350		Home visit est patient	NA	NA	NA	178.95	179.38	0
G0008		Immunization admin	NA	NA	NA	25.51	25.42	0

[1] CPT codes and descriptions are copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] Payments based on the July–December 2015 conversion factor of 35.9335.
[3] Payments based on the 2016 conversion factor of $35.8043.

10. On page 71369,

a. Second column, fifth paragraph, line 20, the figure ''$109.28'' is corrected to read ''108.85''.

b. Second column, fifth paragraph, line 23, the figure ''$21.86'' is corrected to read ''21.77''.

List of Subjects in 42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments to part 411:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

■ 2. Section 411.357 is amended:

■ a. In paragraph (d)(1)(iv) by removing the phrase ''is for at least 1 year'' and adding in its place the phrase ''is at least 1 year''.

■ b. In paragraph (x)(1)(vi)(A) by removing the phrase ''The nonphysician practitioner has a compensation arrangement with'' and adding in its place the phrase ''The nonphysician practitioner has a compensation arrangement directly with''.

Dated: February 29, 2016.

Wilma Robinson,

Deputy Executive, Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2016–05054 Filed 3–7–16; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 140117052–4402–02]

RIN 0648–XE449

Fisheries of the Northeastern United States; Summer Flounder Fishery; Quota Transfer

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; quota transfer.

SUMMARY: NMFS announces that the State of North Carolina is transferring portions of its 2016 commercial summer flounder quota to the States of New Jersey and Rhode Island, and the Commonwealths of Virginia and Massachusetts. These quota adjustments are necessary to comply with the Summer Flounder, Scup and Black Sea Bass Fishery Management Plan quota transfer provision. This announcement informs the public of the revised commercial quota for each state involved.

DATES: Effective March 7, 2016, through December 31, 2016.

FOR FURTHER INFORMATION CONTACT: Elizabeth Scheimer, Fishery Management Specialist, (978) 281–9236.

SUPPLEMENTARY INFORMATION:

Regulations governing the summer flounder fishery are in 50 CFR 648.100 through 50 CFR 648.110. The regulations require annual specification of a commercial quota that is apportioned among the coastal states from Maine through North Carolina. The process to set the annual commercial quota and the percent allocated to each state are described in § 648.102.

The final rule implementing Amendment 5 to the Summer Flounder Fishery Management Plan, as published in the **Federal Register** on December 17, 1993 (58 FR 65936), provided a mechanism for transferring summer flounder commercial quota from one state to another. Two or more states, under mutual agreement and with the concurrence of the NMFS Greater Atlantic Regional Administrator, can transfer or combine summer flounder commercial quota under § 648.102(c)(2). The Regional Administrator is required to consider the criteria in § 648.102(c)(2)(i)(A) through (C) in the evaluation of requests for quota transfers or combinations.

North Carolina is transferring a total of 64,978 lb (29,473 kg) of summer flounder commercial quota to the following states: New Jersey, 13,200 lb (5,987 kg); Massachusetts, 9,805 lb (4,447 kg); Virginia, 30,573 lb (13,868 kg); and Rhode Island, 11,400 lb (5,171 kg). These transfers were requested by the State of North Carolina to repay landings by North Carolina permitted vessels that landed in these other states under safe harbor agreements.

The revised summer flounder quotas for calendar year 2016 are: North Carolina, 2,164,731 lb (981,905 kg); Virginia, 1,762,354 lb (799,390 kg); Rhode Island, 1,285,491 lb (583,089 kg); Massachusetts, 563,902 lb (255,782 kg); and New Jersey, 1,371,944 lb (622,303 kg), based on the quotas published in the 2016–2018 Summer Flounder, Scup

and Black Sea Bass Specifications, (December 28, 2015, 80 FR 80689).

Classification

This action is taken under 50 CFR part 648 and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: March 3, 2016.

Emily H. Menashes,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2016–05132 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–22–P

Proposed Rules

Federal Register
Vol. 81, No. 45
Tuesday, March 8, 2016

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 870

RIN 3206–AN21

Federal Employees' Group Life Insurance Program: Filing Deadlines for Court Review of Administrative Final Decisions; Withdrawal of Proposed Rule

AGENCY: U.S. Office of Personnel Management.

ACTION: Withdrawal of proposed rule.

SUMMARY: The United States Office of Personnel Management (OPM) issued a proposed rule on January 12, 2016 to amend the Federal Employees' Group Life Insurance (FEGLI) Program regulations to establish a timeframe for filing civil actions or claims against the United States based on 5 U.S.C. chapter 870 (Life Insurance). OPM is withdrawing the proposed rule to undertake further analysis of the subject matter referenced in the proposed rule.

DATES: The proposed rule published on January 12, 2016 at 81 FR 1336 is withdrawn effective March 8, 2016.

FOR FURTHER INFORMATION CONTACT: Ronald Brown, Policy Analyst, Planning and Policy Analysis, U.S. Office of Personnel Management, Room 4312, 1900 E Street NW., Washington, DC 20415; or FAX to 202–606–0636 Attn: Ronald Brown.

SUPPLEMENTARY INFORMATION: The United States Office of Personnel Management (OPM) issued a proposed rule on January 12, 2016, at 81 FR 1336. This proposed rule was intended to: (1) Establish a timeframe for filing legal action for judicial review of OPM or employing agency final action on FEGLI claims; and (2) provide a 3-year time limit for filing a court claim for review of agency or retirement system final decisions.

The OPM is withdrawing this proposed rule to undertake further analysis of the subject matter referenced in the proposed rule.

U.S. Office of Personnel Management.

Beth F. Cobert,

Acting Director.

[FR Doc. 2016–05118 Filed 3–7–16; 8:45 am]

BILLING CODE 6325–63–P

DEPARTMENT OF HOMELAND SECURITY

Customs and Border Protection

8 CFR Part 212

RIN 1651–AA97

[USCBP–2016–0006]

Waiver of Passport and Visa Requirements Due to an Unforeseen Emergency

AGENCY: U.S. Customs and Border Protection, DHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: This rule proposes to reinstate a 1996 amendment to a regulation in title 8 of the Code of Federal Regulations regarding a discretionary waiver of certain documentary requirements for nonimmigrants seeking admission to the United States. The 1996 amendment allowed the legacy Immigration and Naturalization Service (INS) (now U.S. Customs and Border Protection) to waive passport and visa requirements for nonimmigrants due to an unforeseen emergency while preserving its ability to fine carriers for unlawfully bringing aliens who do not have a valid passport or visa to the United States. The U.S. Court of Appeals for the Second Circuit ruled that the legacy INS and the U.S. Department of State (State Department) did not satisfy a statutory requirement to act jointly when the amendment was promulgated. As a result, the court found that the 1996 amendment to the regulation was procedurally deficient and reimposed an earlier version of the regulation that legacy INS and the State Department promulgated in 1994.

This rule proposes to reinstate the 1996 amendment with some technical amendments. DHS and the State Department have acted jointly in this matter and the State Department is publishing a parallel proposed rule to amend its regulation in today's edition of the **Federal Register**.

DATES: Comments must be received on or before May 9, 2016.

FOR FURTHER INFORMATION CONTACT: Joseph O'Donnell, Fines, Penalties and Forfeitures, Office of Field Operations, 202–344–1691.

ADDRESSES: You may submit comments, identified by docket number, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments via docket number USCBP–2016–0006.
- *Mail:* Border Security Regulations Branch, Office of Regulations and Rulings, U.S. Customs and Border Protection, 90 K Street NE.,10th Floor, Washington, DC 20229–1177.

Instructions: All submissions received must include the agency name and docket number for this rulemaking. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. For detailed instructions on submitting comments and additional information on the rulemaking process, see the ''Public Participation'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.* Submitted comments may also be inspected during regular business days between the hours of 9 a.m. and 4:30 p.m. at the Office of International Trade, Regulations and Rulings, U.S. Customs and Border Protection, 90 K Street NE.,10th Floor, Washington, DC. Arrangements to inspect submitted comments should be made in advance by calling Mr. Joseph Clark at (202) 325–0118.

SUPPLEMENTARY INFORMATION:

Public Participation

Interested persons are invited to participate in this rulemaking by submitting written data, views, or arguments on all aspects of the proposed rule. U.S. Customs and Border Protection (CBP) also invites comments that relate to the economic, environmental or federalism effects that might result from this proposed rule. Comments that will provide the most assistance to CBP will reference a specific portion of the proposed rule, explain the reason for any recommended change, and include data, information, or authority that support such recommended change.

Background

In general, nonimmigrant aliens must present an unexpired passport and, if required, a valid unexpired visa in order to be admitted to the United States. *See* section 212(a)(7)(B)(i) of the Immigration and Nationality Act, as amended (INA) (8 U.S.C. 1182(a)(7)(B)(i)). The Secretary of Homeland Security and the Secretary of State, acting jointly, in specified situations, as provided in section 212(d)(4) of the INA (8 U.S.C. 1182(d)(4)), may waive either or both of these requirements.[1] One of these situations is when the the agencies determine ''in individual cases'' that the nonimmigrant is unable to present the required documents due to an unforeseen emergency. *See* section 212(d)(4)(A) of the INA (8 U.S.C. 1182(d)(4)(A)). DHS regulations list those classes of persons who are not required to present a visa (or passport, in some cases) in 8 CFR 212.1. The unforeseen emergency waiver is provided for in 8 CFR 212.1(g).[2] The State Department has a similar provision in 22 CFR part 41.

1994 Regulatory Amendment

On January 11, 1994, the legacy INS and the State Department each issued final rules amending their respective regulations to simplify the administrative procedure for granting unforeseen emergency waivers. See 59 FR 1467 and 59 FR 1473 (Jan. 11, 1994). The amended INS regulation (referred to in this document as the 1994 version of 212.1(g)) provided that the district director would have authority to grant a waiver of the passport and/or visa requirements under section 212(d)(4)(A) of the INA without the prior concurrence of the Department of State. Previously, the legacy INS needed to seek the concurrence of the State Department Visa Office prior to granting a waiver. The amended regulation also provided that a visa and a passport are not required of a nonimmigrant who satisfies the district director that the documents cannot be presented due to an unforeseen emergency. Specifically, the legacy INS amended 8 CFR 212.1(g) to provide that a visa and a passport are not required of a nonimmigrant who, either prior to his or her embarkation at a foreign port or place or at the time of arrival at a port of entry in the United States, satisfies the district director at the port of entry that, because of an unforeseen emergency, he or she is unable to present the required documents, in which case a waiver application shall be made on Form I–193. The amended regulation also provided that the district director may approve a waiver of documents in each case in which he or she is satisfied that the nonimmigrant cannot present the required documents because of an unforeseen emergency and the waiver would be appropriate in the circumstances. *See* 59 FR 1467–68.

The amended State Department regulation, 22 CFR 41.2(j), contained similar provisions.[3]

1996 Regulatory Amendment

On March 22, 1996, the legacy INS published a final rule that amended the unforeseen emergency waiver in 8 CFR 212.1(g). *See* 61 FR 11717. Among other things, the legacy INS final rule removed the statement that a ''visa and a passport are not required of a nonimmigrant who . . . satisfies the district director at the port of entry that, because of an unforeseen emergency, he or she is unable to present the required documents. . . .'' The legacy INS replaced this language with general language about the documentary requirements for a nonimmigrant seeking admission to the United States, a statement authorizing the legacy INS to waive the documentary requirements because of an unforeseen emergency, and a statement authorizing the legacy INS to revoke such a waiver. The amended text (referred to in this document as the 1996 version of 212.1(g)) provided that a nonimmigrant seeking admission to the United States must present an unexpired visa and a passport valid for the amount of time set forth in section 212(a)(7)(B) of the Act, or a valid border crossing identification card at the time of application for admission, unless the nonimmigrant satisfies the requirements described in one or more of the paragraphs (a) through (f) or (i) of 8 CFR 212.1. The amended text also provided that upon a nonimmigrant's application on Form I–193, a district director at a port of entry may, in the exercise of his or her discretion, on a case-by-case basis, waive the documentary requirements, if satisfied that the nonimmigrant cannot present the required documents because of an unforeseen emergency. Finally, the amended text provided that the district director or the Deputy Commissioner may at any time revoke a waiver previously authorized pursuant to this paragraph and notify the nonimmigrant in writing to that effect. *See* 61 FR 11720–21.

One important distinction between the 1994 and 1996 versions of section 212.1(g) is that the 1994 version specifies that a visa and passport ''are not required'' of a nonimmigrant if the legacy INS (now CBP) concludes that the nonimmigrant is unable to present the required documents because of an unforeseen emergency. In contrast, the 1996 version does not include the phrase ''are not required.'' The absence of that language supported the legacy INS' authority to fine carriers that transported aliens without a valid passport or visa even where the alien is granted a discretionary waiver under section 212(d)(4) of the INA.[4] Section 273 of the INA (8 U.S.C. 1323) makes it unlawful for any person or company to bring an alien to the United States (other

[1] Previously, the Attorney General acting jointly with the Secretary of State was authorized to waive the documentary requirements due to an unforeseen emergency. However, pursuant to the Homeland Security Act of 2002, Public Law 107–296, 116 Stat. 2135 (HSA), as of March 1, 2003, functions of the legacy INS of the Department of Justice and the legacy U.S. Customs Service of the Department of the Treasury were transferred to DHS. Specifically, pursuant to sections 102(a), 441, 1512(d) and 1517 of the HSA and 8 CFR 2.1, the authorities of the Attorney General, as described in section 212 of the INA (8 U.S.C. 1182), were transferred to the Secretary of Homeland Security, and the reference to the Attorney General in the statute is deemed to refer to the Secretary. Thus, the waiver authority in section 212 of the INA therefore now resides with the Secretary of Homeland Security acting jointly with the Secretary of State.

[2] An example of an unforeseen emergency may be where a nonimmigrant loses his or her passport and/or visa or has these documents stolen immediately prior to departure for the United States, and does not have time to obtain replacement documents.

[3] The amended State Department regulation provided that a visa and passport are not required of an alien if, either prior to the alien's embarkation abroad or upon arrival at a port of entry, the responsible district director of the Immigration and Naturalization Service in charge of the port of entry concludes that the alien is unable to present the required documents because of an unforeseen emergency. The amended State Department regulation further provided that any waiver of the visa or passport requirement may be granted by the INS district director pursuant to INA 212(d)(4)(A) without the prior concurrence of the Department of State in each case in which the district director concludes that the alien's claim of emergency circumstances is legitimate and bona fide and that approval of the waiver would be appropriate under all of the attendant facts and circumstances. *See* 59 FR 1473 (Jan. 11, 1994).

[4] The Board of Immigration Appeals (Board) supported legacy INS' interpretations of both the 1994 and 1996 versions of 8 CFR 212.1(g). Prior to the 1996 amendment to the regulation, the Board had held ''that liability to fine was not incurred . . . for bringing to the United States a nonimmigrant alien without a valid visa when such alien was paroled into the United States *and was subsequently granted a waiver of the nonimmigrant visa.'' Matter of United Airlines Flight UA802,* 22 I&N Dec. 777, 780 (BIA 1999) (*citing Matter of ''Flight SR–4'',* 10 I&N Dec. 197 (BIA 1963)). However, in *Matter of Finnair Flight AY103,* 23 I&N Dec. 140 (BIA 2001), the Board held that a carrier was subject to a fine for bringing an alien passenger to the United States without a valid nonimmigrant visa even though the passenger was subsequently granted a waiver of the documentary requirements under the 1996–amended version of the regulation.

than from a foreign contiguous territory) who does not have a valid passport and an unexpired visa (if a visa is required), including under controlling regulations, and authorizes a fine against the carrier for each alien unlawfully brought into the United States.[5] On May 28, 1999, the State Department amended 22 CFR 41.2(j) in a similar manner.[6] See 64 FR 28915.

Litigation Challenging the 1996 Regulation

Numerous airlines challenged the 1996 version of 212.1(g) in the U.S. District Court for the Eastern District of New York. Legacy INS had fined certain airlines for bringing undocumented aliens into the United States in violation of section 273 of the INA (8 U.S.C. 1323) even though some of the undocumented aliens had been granted unforeseen emergency waivers pursuant to 8 CFR 212.1(g) after the aliens arrived in the United States. Section 273 of the INA makes it unlawful for any person or company to bring an alien to the United States (other than from a foreign contiguous territory) who does not have a valid passport and an unexpired visa, if a visa was required, and authorizes a $4,300 fine against the carrier for each alien unlawfully brought into the United States.[7] Legacy INS believed that granting unforeseen emergency waivers did not preclude the imposition of fines under section 273 of the INA on the airlines transporting such waiver recipients.

Several of the airlines that legacy INS fined claimed that the fines were not authorized because the 1996 version of 212.1(g) was void due to procedural defects. Specifically, they claimed that the INA required joint action between the legacy INS and State Department and that the 1996 version of 212.1(g) was deficient because the legacy INS acted on its own when promulgating the regulation. If the 1996 version was void, the 1994 version of 212.1(g) would control. As described above, the 1994 version specified that ''a visa and passport are not required'' of a nonimmigrant if the INS concludes that the nonimmigrant is unable to present the required documents because of an unforeseen emergency. Under this version, the legacy INS did not assess carrier fines for bringing in aliens who were unable to present a valid, unexpired visa and passport due to an unforeseen emergency.

1996 Regulation Found to Have Been Improperly Promulgated

The district court ruled in favor of the legacy INS on this issue and the airlines appealed. On November 20, 2009, the United States Court of Appeals for the Second Circuit issued its opinion in *United Airlines, Inc.* v. *Brien*, 588 F.3d 158 (2d Cir. 2009), a consolidated appeal from three final orders of the lower court. Although the Second Circuit agreed with the Government's view that the 1996 version of 8 CFR 212.1(g) would not have precluded the assessment of carrier fines when an unforeseen emergency waiver had been granted, it held that the 1996 amendment was void because it was improperly promulgated. The Court stated that section 212(d)(4)(A) of the INA ''requires joint action, and the two agencies acted jointly when enacting the pre-1996 version of the regulation.'' *United Airlines*, 588 F.3d at 179. The Court further stated that ''[t]he INS's attempt to amend the jointly enacted regulation on its own, therefore, [wa]s ineffective, and the pre-1996 version remains in effect'' and that ''[t]he INS's failure to coordinate with the State Department in the amendment of the regulations render[ed] the 1996 amendment void.'' *Id.* The Court also found that the 1999 State Department amendment of its regulation violated the joint action requirement, that the amendment should have undergone notice and comment rulemaking before being adopted, and that ''the prior versions of both agencies' regulations remain effective until the two agencies act *jointly* to amend them.'' *Id.* at 180 (emphasis in original). As a result, the Court invalidated the 1996 amendment to 8 CFR 212.1(g), as well as subsequent amendments to the regulation made in 2002 and 2007.[8] The Court reinstated the 1994 version of the regulation.

Proposal

DHS is now proposing to reinstate the 1996, 2002 and 2007 amendments to 8 CFR 212.1(g). DHS and the State Department have consulted and are each proposing parallel and simultaneous amendments to 8 CFR 212.1(g) and 22 CFR 41.2(i), respectively, to reinstate the 1996, 2002 and 2007 amendments to 8 CFR 212.1(g) and the 1999 amendments to 22 CFR 41.2(i).[9] The State Department's Notice of Proposed Rulemaking is published in today's **Federal Register**. The issuance of parallel regulations was specifically sanctioned by the Court in *United Airlines* when it noted that ''[t]he 1999 State Department amendment, like the 1996 INS amendment, violated the joint action requirement, and the prior versions of both agencies' regulations remain effective until the two agencies act jointly to amend them.'' 588 F.3d at 180.

With these amendments, DHS will be able to assess carrier fines under section 273 of the INA in appropriate cases notwithstanding that an ''unforeseen emergency'' waiver had been granted under section 212(d)(4)(A) of the Act and 8 CFR 212.1(g).[10]

Regulatory Analyses

A. Executive Order 13563 and Executive Order 12866

Executive Orders 13563 and 12866 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule is a ''significant regulatory action,'' although not an economically significant regulatory action, under section 3(f) of Executive Order 12866. Accordingly, the Office of Management and Budget has reviewed this regulation.

In 1996, the legacy INS published a final rule (61 FR 11717) amending 8 CFR 212.1(g) which allowed for the waiver of the requirement of proper entry documentation for a

[5] Section 212(a)(7)(B)(i) of the INA, which concerns only nonimmgrants, uses the term ''nonimmigrant.'' Section 273 of the INA, which concerns immigrant and nonimmigrant aliens, uses the term ''alien.'' This document will generally use the term ''nonimmigrant'' when discussing the waiver provision contained in section 212(d)(4) of the INA or 8 CFR 212.1(g) and use the term ''alien'' when discussing the fines provision contained in section 273.

[6] The legacy INS amended 8 CFR 212.1(g) on two occasions in 2002. First, it added a reference to section 212.1(o). 67 FR 4784 (Jan. 31, 2002). Second, it updated the documentary requirements by adding the phrase '', issued by the DOS on Form DSP 150.'' Finally, DHS amended this provision in 2007 to add U nonimmigrants to the list of nonimmigrants who are not required to satisfy the visa and passport requirement under section 212(a)(7)(B) of the INA consistent with other regulatory provisions. *See* 8 CFR 212.1(p).

[7] DHS adjusted the statutory fine of $3,000 to $4,300 to account for inflation. *See* 76 FR 74625 (Dec. 1, 2011).

[8] The INS amended the regulation in 2002 to update documentary requirements, and DHS amended the regulation in 2007 to include U nonimmigrants among those who could seek a waiver. *See* 67 FR 71443 (Dec. 2, 2002) and 72 FR 53014 (Sept. 17, 2007).

[9] 22 CFR 41.2(j) was redesignated as 22 CFR 41.2(i) in 2016. *See* 81 FR 5908.

[10] CBP generally would not consider it appropriate to apply a fine if CBP granted the waiver prior to the nonimmigrant alien's boarding.

nonimmigrant in an unforeseen emergency while still retaining the ability to fine the carrier for transporting an alien to the United States without proper entry documentation. In 2009, the U.S. Court of Appeals for the Second Circuit issued an opinion in *United Airlines, Inc.* v. *Brien,* 588 F.3d 158 (2d Cir. 2009) which held that the regulation amending 8 CFR 212.1(g) was improperly promulgated because the State Department and the legacy INS did not jointly promulgate the rule. In its ruling, the Court upheld CBP's right to issue fines under section 273 of the INA when aliens do not receive a waiver but are otherwise allowed to enter the United States without proper documents, such as when they are paroled into the United States.[11] This has led to a situation where carriers are being penalized inconsistently when they transport aliens to the United States without proper documentation. If an alien qualifies for parole, the carrier is fined. If an alien does not qualify for parole but receives a waiver, the carrier is not fined. Since the carrier is equally violative in these situations, CBP believes the penalties should be the same for each.

As such, DHS (functions of the legacy INS were transferred to DHS in 2003) and the State Department are now jointly promulgating rules to allow CBP to waive the requirement to present entry documents for nonimmigrants under an unforeseen emergency while still retaining the ability to fine the carrier a maximum penalty of $4,300 for transporting an alien to the United States without proper entry documentation.

From FY 2010–2015, if this proposed rule had been in effect, carriers would have been subject to penalties averaging $1.7 million per year for 950 violations to section 273 of the INA. This $1.7 million represents a transfer from violative carriers to the United States government. To avoid the penalties imposed by this rule and existing penalties, carriers may adopt further oversight. CBP requests comment on any additional oversight costs that could result from this rule.

[11] An alien may be paroled into the United States when he or she appears to be inadmissible to the inspecting officer but is allowed into the United States for urgent humanitarian reasons or when that alien's entry is determined to be for significant public benefit. Parole does not constitute an admission to the United States and shall be terminated when, *inter alia,* the purpose of parole is accomplished or neither humanitarian reasons nor public benefit warrants the continued presence of the alien in the United States. *See* 8 CFR 212.5(e). *See http://www.dhs.gov/definition-terms* for information on various types of parole.

CBP currently issues penalties under this provision to any carriers that transport aliens without proper documents who are inadmissible, including when these aliens qualify for parole. Therefore, CBP will not have to set up a new process to fine carriers as a result of this rule. A penalty under this provision takes CBP approximately 2.5 hours to process. Therefore, on average this rule would take approximately 2,375 hours a year for CBP to administer.

Currently, carriers are penalized for violations of section 273 inconsistently. When a carrier transports an alien without proper documentation, whether it is penalized depends not on the nature of the carrier's violation, but on whether the alien it transported qualifies for a waiver. CBP believes it is more equitable to penalize carriers who violate section 273 equally. Additionally, CBP believes that the penalty provisions in the proposed regulation provide an economic incentive to enforce the statutory requirements of section 273 of the INA.

For additional analysis on the impacts of this rule on small entities and a discussion of alternatives, see section B. Regulatory Flexibility Act.

B. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), as amended by the Small Business Regulatory Enforcement and Fairness Act of 1996, requires agencies to assess the impact of regulations on small entities. A small entity may be a small business (defined as any independently owned and operated business not dominant in its field that qualifies as a small business per the Small Business Act); a small not-for-profit organization; or a small governmental jurisdiction (locality with fewer than 50,000 people).

As discussed above, DHS and the State Department are proposing parallel and simultaneous amendments to 8 CFR 212.1(g) and 22 CFR 41.2(i) respectively, that would allow CBP to waive the passport and/or visa requirements for nonimmigrants due to an unforeseen emergency while retaining the ability to enforce the statutory requirement imposing a maximum penalty of $4,300 on a carrier for transporting an alien to the United States without proper documentation.

The Regulatory Flexibility Act does not specify thresholds for economic significance but instead gives agencies flexibility to determine the appropriate threshold for a particular rule. CBP believes that a maximum penalty of $4,300 may be considered a significant economic impact given the wide range of companies subject to the requirements of this rule and that it is possible that a specific small entity may receive more than one penalty in a year. Therefore CBP is preparing an Initial Regulatory Flexibility Analysis under section 603 of the Regulatory Flexibility Act.

It is unlawful under section 273 of the INA for any person or company to transport an alien to the United States (other than from a foreign contiguous territory) who does not have a valid passport and an unexpired visa (if a visa is required). 8 U.S.C. 1323. As such, it is possible that any person or company engaged in the transportation of aliens may be affected by the proposed rule. Below, Table 1 presents data on the industries CBP has identified that could be affected by this rule. While CBP finds that only 41 small entities have violated section 273 of the INA from FY 2008 to FY 2012, CBP is unable to certify that substantial number of small entities will not be affected by the proposed regulation in the future.[12]

CBP is choosing not to certify that this rule will not have a significant economic impact on a substantial number of small entities. Accordingly, CBP has conducted the following Initial Regulatory Flexibility Analysis.

1. A Description of the Reasons Why Action by the Agency Is Being Considered

In 1996, the legacy INS published a final rule (61 FR 11717) amending 8 CFR 212.1(g) which allowed for the waiver of the requirement of proper entry documentation for a nonimmigrant in an unforeseen emergency while still retaining the ability to fine the carrier for transporting an alien to the United States without proper entry documentation. In 2009, the U.S. Court of Appeals for the Second Circuit issued an opinion in *United Airlines, Inc.* v. *Brien,* 588 F.3d 158 (2d Cir. 2009) which held that the regulation amending 8 CFR 212.1(g) was improperly promulgated because the State Department and the legacy INS did not jointly promulgate the rule. As such, DHS (functions of the legacy INS were transferred to DHS in 2003) and the State Department are now jointly promulgating rules to allow CBP to waive the requirement to present entry documents for nonimmigrants under an unforeseen emergency while still

[12] Since November 20, 2009 CBP has been unable to impose a penalty when a section 212(d)(4)(A) waiver has been granted to an alien without proper documentation. Nevertheless, the small entities listed in Table 1 transported aliens who received such waivers. The small entities responsible for transporting the aliens were not assessed a penalty.

retaining the ability to fine the carrier for transporting an alien to the United States without proper entry documentation. CBP believes that the penalty provisions in the proposed regulation provide the necessary economic incentive to enforce the statutory requirements of section 273 of the INA.

2. A Succinct Statement of the Objectives of, and Legal Basis for, the Proposed Rule

The objective of this regulation is to allow CBP to waive the requirement of proper entry documents for nonimmigrants in an unforeseen emergency while still retaining the ability to fine the carrier for transporting an alien to the United States without proper entry documentation. In general, nonimmigrant aliens must present an unexpired passport and, if required, a valid unexpired visa in order to be admitted to the United States. See section 212(a)(7)(B)(i) of the INA (8 U.S.C. 1182(a)(7)(B)(i)). The Secretary of Homeland Security and the Secretary of State, acting jointly, in specified situations, as provided in section 212(d)(4) of the INA (8 U.S.C. 1182(d)(4)), may waive either or both of these requirements. One of these situations is when the nonimmigrant is unable to present the required documents due to an unforeseen emergency. See section 212(d)(4)(A) of the INA. DHS regulations list those classes of persons who are not required to present a visa (or passport, in some cases) in 8 CFR 212.1. The unforeseen emergency waiver is provided for in 8 CFR 212.1(g). The State Department has a similar provision in 22 CFR part 41.

3. A Description of and, Where Feasible, an Estimate of the Number of Small Entities to Which the Proposed Rule Will Apply

It is unlawful under section 273 of the INA for any person or company to transport an alien to the United States (other than from a foreign contiguous territory) who does not have a valid passport and an unexpired visa (if a visa is required). As such, it is possible that any person or company engaged in the transportation of aliens may be affected by this rule. Below, Table 1 presents data on the industries CBP estimates could be affected by this rule. The data include the NAICS codes of an industry, a description of the industry, and the Small Business Administration's (SBA) guidance on what qualifies an entity to be considered small in the respective industry. Additionally, Table 1 includes the number small entities in the respective industry that have violated section 273 of the INA from FY 2008 through FY 2012.[13] Of the industries that could be affected, only four industries have had small entities that have violated section 273 of the INA from FY 2008 through FY 2012.

TABLE 1

NAICS	Industry description	SBA size standard	Small entities that have violated section 273 of the INA
481111	Scheduled Passenger Air Transportation	<1,500 employees	0
481112	Scheduled Freight Air Transportation	<1,500 employees	0
481211	Nonscheduled Chartered Passenger Air Transportation	<1,500 employees	16
481212	Nonscheduled Chartered Freight Air Transportation	<1,500 employees	0
481219	Other Nonscheduled Air Transportation	<$14 million in revenue	0
482111	Line-Haul Railroads	<1,500 employees	0
482112	Short Line Railroads	<500 employees	0
483111	Deep Sea Freight Transportation	<500 employees	1
483112	Deep See Passenger Transportation	<500 employees	0
483113	Coastal and Great Lakes Freight Transportation	<500 employees	0
483114	Coastal and Great Lakes Passenger Transportation	<500 employees	0
483211	Inland Water Freight Transportation	<500 employees	0
483212	Inland Water Passenger Transportation	<500 employees	1
484230	Specialized Freight (except, Used Goods) Trucking, Long-Distance	<$25.5 million in revenue	0
485991	Special Needs Transportation	<$14 million in revenue	0
487110	Scenic and Sightseeing Transportation, Land	<$7 million in revenue	0
488330	Navigational Services to Shipping	<$35.5 million in revenue	0
541614	Process, Physical Distribution and Logistics Consulting Services	<$14 million in revenue	23
621910	Ambulance Services	<$14 million in revenue	0

Sources: U.S. Census Bureau, Small Business Administration, and CBP.

To estimate the number of small entities to which the proposed rule will apply, CBP needs an estimate of the total number of small entities within an industry and the number of these small entities that are, or will be, engaged in the transportation of aliens.

The U.S. Census Bureau (Census) provides estimates of the number of entities within an industry. The Census organizes an industry by various intervals of annual revenue and number of employees.[14] Using these intervals and the SBA's small entity standards, CBP can estimate the number of small entities within an industry. However, the Census intervals do not necessarily correspond exactly with the SBA's small entity size standards. As an example, as shown in Table 2 below, the SBA's small entity size standards state that an entity classified under NAICS code 481211 is small if it has fewer than 1,500 employees. The Census, however, only has the following intervals of employees: 0–4 employees, 5–9 employees, 10–19 employees, 20–99 employees, 100–499 employees, and 500+ employees. It is not possible to differentiate between the entities in the 500+ employee interval that would be considered small under SBA's small entity size standards (entities with fewer

[13] Since November 20, 2009, CBP has been unable to impose a penalty when a 212.1(g) waiver has been granted to an alien without proper documentation. Nevertheless, the small entities listed in Table 1 transported aliens who received 212.1(g) waivers. The small entities responsible for transporting the aliens were not assessed a penalty.

[14] *http://www.census.gov/econ/susb/.*

than 1,500 employees) and those entities the SBA does not consider small (entities with more than 1,500 employees). We therefore, sought an alternative data source to supplement the Census data. Any scheduled airline with a capacity of carrying over 18,000 pounds is required to report employee information to the Department of Transportation.[15] Using this data, we were able to identify carriers with over 1,500 employees, who are not considered small entities under the SBA size standards. We subtracted these airlines from the total small entities in each NAICS code to estimate the total small entities that could be affected by this rule. We note that these estimates could include businesses with over 1,500 employees that have a payload of less than 18,000 pounds or that do not offer scheduled flights. As there are a large number of small businesses with over 18,000 pounds of capacity, as shown in DOT's data, we do not believe there are many, if any, large carriers that are not included in DOT's data. We request comment on this matter.

Although CBP can use the Census and DOT data to provide an estimate of the number of small entities that have the potential to be affected by this rule, CBP cannot use the Census data to determine the number of small entities that are, or will be, engaged in the transportation of aliens within a reasonable degree of accuracy.[16] As shown in both Tables 1 and 2, however, CBP's internal records show that only 41 small entities from FY 2008 to FY 2012 violated section 273 of the INA and thus would have been subject to a penalty if this rule were in effect. CBP seeks comment on the number of small entities that are, or will be, engaged in the transportation of aliens.

TABLE 2

NAICS	Industry description	SBA Size Standard	Total number of entities	Total number of small entities	Small entities that have violated section 273 of the INA
481111	Scheduled Passenger Air Transportation	<1,500 employees	258	233	0
481112	Scheduled Freight Air Transportation	<1,500 employees	232	227	0
481211	Nonscheduled Chartered Passenger Air Transportation.	<1,500 employees	1498	1498	16
481212	Nonscheduled Chartered Freight Air Transportation.	<1,500 employees	171	171	0
481219	Other Nonscheduled Air Transportation	$14 million in revenue.	476	477	0
482111	Line-Haul Railroads	<1,500 employees	not available	not available	0
482112	Short Line railroads	<500 employees	not available	not available	0
483111	Deep Sea Freight Transportation	<500 employees	231	213	1
483112	Deep See Passenger Transportation	<500 employees	48	41	0
483113	Coastal and Great Lakes Freight Transportation.	<500 employees	376	350	0
483114	Coastal and Great Lakes Passenger Transportation.	<500 employees	170	170	0
483211	Inland Water Freight Transportation	<500 employees	319	294	0
483212	Inland Water Passenger Transportation	<500 employees	235	233	1
484230	Specialized Freight (except, Used Goods) Trucking, Long-Distance.	$25.5 million in revenue.	9,839	9,476	0
485991	Special Needs Transportation	$14 million in revenue.	2,130	2,026	0
487110	Scenic and Sightseeing Transportation, Land.	$7 million in revenue	646	121	0
488330	Navigational Services to Shipping	$35.5 million in revenue.	728	693	0
541614	Process, Physical Distribution and Logistics Consulting Services.	$14 million in revenue.	6,379	6,058	23
621910	Ambulance Services	$14 million in revenue.	3,150	2,941	0

Sources: U.S. Census Bureau, Small Business Administration, and CBP.

4. A Description of the Projected Reporting, Recordkeeping and Other Compliance Requirements of the Proposed Rule, Including an Estimate of the Classes of Small Entities Which Will Be Subject to the Requirement and the Type of Professional Skills Necessary for Preparation of the Report or Record

The proposed regulation does not propose changes to any required reporting, recordkeeping, or compliance requirements. The objective of the proposed rule is to allow CBP in an unforeseen emergency to waive the requirement that a nonimmigrant present proper entry documents in order to be admitted into the United States while retaining the ability to fine the carrier that did not comply with the requirements pertaining to the proper transportation of an alien to the United States. When the nonimmigrant without proper documentation is not admitted, including when he or she is granted parole, CBP already has the authority to fine the carrier that did not comply with the requirements. This rule would only affect the carriers transporting aliens for whom CBP waives the document requirement. As discussed above, the proposed rule could affect any small entity that transports an alien without proper entry documentation.

[15] *http://transtats.bts.gov/Employment/.*

[16] For instance, CBP cannot tell which scheduled passenger air transportation entities do, or will, transport aliens and which do, or will, not transport aliens.

5. An Identification, to the Extent Practicable, of All Relevant Federal Rules Which May Duplicate, Overlap or Conflict With the Proposed Rule

The State Department is jointly promulgating this rule with DHS. DHS does not view this as duplicative, overlapping, or in conflict with this proposed rule as it is a judicial requirement stemming from the opinion in *United Airlines, Inc.* v. *Brien,* 588 F.3d 158 (2d Cir. 2009), which held that the 8 CFR 212.1(g) was improperly promulgated because the State Department and the legacy INS did not promulgate the rule jointly.

6. A Description of Any Significant Alternatives to the Proposed Rule Which Accomplish the Stated Objectives of Applicable Statutes and Which Minimize Any Significant Economic Impact of the Proposed Rule on Small Entities

Alternative 1 (chosen alternative): Allows CBP to waive the requirement for nonimmigrants to present valid documentation for entry into the United States in an unforeseen emergency while retaining the ability to enforce the statutory requirement imposing a maximum penalty of $4,300 on a carrier, regardless of size, for transporting an alien to the United States without proper documentation. When the nonimmigrant without proper documentation is not admitted, including when he or she is granted parole, CBP already has the authority to fine the carrier that did not comply with the requirements.

Alternative 2: Same as Alternative 1, but waive the penalty in Alternative 1 for small entities.

Alternative 3: No regulatory action (*i.e.* the world as it is now).

CBP has chosen to implement Alternative 1. CBP believes that a penalty mechanism is necessary in order to enforce the statutory prohibition on transporting aliens into the United States without proper documentation. In addition, this rule would end the current inconsistency in fines for violations of section 273. Finally, CBP believes that the penalty provisions in the proposed regulation provide an economic incentive to enforce the statutory requirements of section 273 of the INA.

Alternative 2 would eliminate the economic impact of the proposed rule on noncompliant small entities. CBP believes that it would also eliminate economic incentive to enforce the statutory requirement for small entities. Furthermore, 8 CFR 273.5 sets forth the mitigation criteria for the mitigation of fines under § 273(e) of the INA and applies the administrative procedures provided for in 8 CFR 280.12 and 280.51. In determining the amount of the mitigation, CBP may take into account the effectiveness of the carrier's screening procedures, the carrier's history of fines, and the existence of extenuating circumstances. This mitigation is available to any carrier, including small entities.

Alternative 3 would eliminate the economic impact of the proposed rule for all noncompliant carriers, regardless of size. In addition, the current inconsistency in fines for violations of section 273 would continue—carriers who transport aliens who qualify for parole would be fined if they do not adhere to the requirements of section 273, but those who transport aliens who qualify for unforeseen emergency waivers would not be fined.

C. Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandate Reform Act of 1995 (UMRA), 2 U.S.C. 1501 *et seq.,* requires agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. This rule will not result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year (adjusted for inflation), and it will not significantly or uniquely affect small governments. Therefore, no actions are necessary under the provisions of the Unfunded Mandates Reform Act of 1995.

D. Executive Order 13132

The rule will not have substantial direct effects on the States, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with section 6 of Executive Order 13132, this rule does not have sufficient federalism implications to warrant the preparation of a federalism summary impact statement.

E. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. 3507) an agency may not conduct, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number assigned by OMB. The collections of information for this NPRM are included in an existing collection for DHS Form I–193 (OMB control number 1651–0107).

List Of Subjects in 8 CFR Part 212

Administrative practice and procedure, Aliens, Immigration, Passports and visas, Reporting and recordkeeping requirements.

Amendments to the Regulations

For the reasons stated in the preamble, DHS proposes to amend part 212 of title 8 of the Code of Federal Regulations (8 CFR part 212), as set forth below:

PART 212—DOCUMENTARY REQUIREMENTS: NONIMMIGRANT; WAIVERS; ADMISSION OF CERTAIN INADMISSIBLE ALIENS; PAROLE

■ 1. The authority citation for part 212 continues to read as follows:

Authority: 8 U.S.C. 1101 and note, 1102, 1103, 1182 and note, 1184, 1187, 1223, 1225, 1226, 1227, 1255, 1359; 8 U.S.C. 1185 note (section 7209 of Pub. L. 108–458); 8 CFR part 2.

■ 2. Section 212.1(g) is revised to read as follows:

§ 212.1 Documentary Requirements for Nonimmigrants.

* * * * *

(g) *Unforeseen emergency.* A nonimmigrant seeking admission to the United States must present an unexpired visa and passport valid for the amount of time set forth in section 212(a)(7)(B)(i) of the Act, 8 U.S.C. 1182(a)(7)(B)(i), or a valid biometric border crossing card issued by the DOS on Form DSP–150, at the time of application for admission, unless the nonimmigrant satisfies the requirements described in one or more of paragraphs (a) through (f) or (i), (o), or (p) of this section. Upon a nonimmigrant's application on Form I–193, or successor form, ''Application for Waiver of Passport and/or Visa,'' a district director may, in the exercise of its discretion, on a case-by-case basis, waive either or both of the documentary requirements of section 212(a)(7)(B)(i) if satisfied that the nonimmigrant cannot present the required documents because of an unforeseen emergency. The district director may at any time revoke a waiver previously authorized pursuant to this paragraph and notify the nonimmigrant in writing to that effect.

* * * * *

Dated: February 29, 2016.

Jeh Charles Johnson,

Secretary.

[FR Doc. 2016–04741 Filed 3–7–16; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2016–4219; Directorate Identifier 2015–NM–169–AD]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for certain The Boeing Company Model 777 airplanes. This proposed AD was prompted by reports of latently failed fuel shutoff valves discovered during fuel filter replacement. This proposed AD would require doing an inspection to identify the part number of the engine fuel spar motor-operated valve (MOV) actuators; replacing certain MOV actuators with new MOV actuators on both airline information management system (AIMS) V1 and V2 equipped airplanes, or installing a newer software version on AIMS V2 equipped airplanes. We are proposing this AD to prevent latent failure of the fuel shutoff valve to the engine. This valve failure, if not prevented, could result in the inability to terminate fuel flow to the engine, which in case of an engine fire, could lead to wing failure.

DATES: We must receive comments on this proposed AD by April 22, 2016.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P.O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone 206–544–5000, extension 1; fax 206–766–5680; Internet *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221. It is also available on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA 2016–4219.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4219; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (phone: 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: David Lee, Aerospace Engineer, Propulsion Branch, ANM–140S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: 425–917–6497; fax: 425–917–6590; email: *david.a.lee@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2016–4219; Directorate Identifier 2015–NM–169–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

We have received reports of latently failed fuel shutoff valves discovered during fuel filter replacement. Deficiencies in the valve actuator design have resulted in latent failures of the fuel shutoff valve to the engine. This condition, if not prevented, could result in the inability to terminate fuel flow to the engine, which in case of an engine fire, could lead to wing failure.

We have previously determined that operators should not be required to replace the two fuel spar valve actuators with new actuators when we previously mandated replacement of MOV actuators for other valve positions in AD 2013–05–03, Amendment 39–17375 (78 FR 17290, March 21, 2013). The alternate MOV actuator configurations available at that time were discovered to be susceptible to latent failures that could result in the inability to shut-off fuel to the engine. We are proposing this AD because a new MOV actuator has become available which corrects the latent failure of an MOV actuator.

We have excluded line numbers 1165 and subsequent from the applicability section of this proposed AD as these airplanes were manufactured new with AIMS–2 Blockpoint Version 17 or higher installed, which are not affected by the unsafe condition.

Related Rulemaking

AD 2013–05–03, Amendment 39–17375 (78 FR 17290, March 21, 2013), for certain The Boeing Company Model 777–200, –200LR, –300, and –300ER series airplanes, requires replacing MOV actuators having part number (P/N) MA20A1001–1 with certain new or serviceable MOV actuators; and measuring the electrical resistance of the bond from the adapter plate to the airplane structure, and doing corrective actions if necessary.

AD 2015–19–01, Amendment 39–18264 (80 FR 55521, September 16, 2015), for certain The Boeing Company Model 777 airplanes, requires revising the maintenance or inspection program to add Airworthiness Limitation (AWL) 28–AWL–MOV for an engine fuel shutoff valve (fuel spar valve) actuator inspection.

On October 30, 2014, we issued an NPRM, Docket No. FAA–2014–0755, Directorate Identifier 2014–NM–080–AD (79 FR 66343, November 7, 2014), for all The Boeing Company Model 737–600, –700, –700C, 800, –900, and –900ER series airplanes, Model 757 airplanes, Model 767 airplanes, and Model 777 airplanes, which would require replacement of any spar-mounted MOV actuator having P/N MA20A1001–1 (S343T003 39) for the fuel tanks or fuel feed system with a serviceable, FAA-approved MOV actuator.

Related Service Information Under 1 CFR Part 51

We reviewed Boeing Service Bulletin 777–28A0034, Revision 3, dated

September 25, 2015. This service information describes procedures for, among other things, inspection and replacement of the main and center fuel tank valve actuators.

We also reviewed Boeing Service Bulletin 777–31–0227, Revision 1, dated August 12, 2015. This service information describes procedures for installing the AIMS 2, Blockpoint Version 17, software upgrade.

This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

We are proposing this AD because we evaluated all the relevant information and determined the unsafe condition described previously is likely to exist or develop in other products of the same type design.

Proposed AD Requirements

This proposed AD would require an inspection to determine the part numbers of installed engine fuel spar MOV actuators; for certain airplanes, replacement of certain MOV actuators with new MOV actuators having part number (P/N) MA30A1017; and for certain other airplanes, replacement of certain MOV actuators with new MOV actuators having P/N MA30A1017, or installation of a certain version of the airplane information management system (AIMS) software; using the Accomplishment Instructions in the service information described previously. For information on the procedures, see this service information at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4219.

Costs of Compliance

We estimate that this proposed AD affects 154 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection (154 airplanes)	1 work-hour X $85 per hour = $85	$0	$85	$13,090.
Replacement of two actuators without fuel tank access (34 airplanes)	5 work-hours X $85 per hour = $425.	12,000	12,425	422,450.
AIMS 2, Blockpoint Version 17, installation (120 airplanes)	7 work-hours X $85 per hour = $595.	0	595	71,400.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII: Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979),

(3) Will not affect intrastate aviation in Alaska, and

(4) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

The Boeing Company: Docket No. FAA–2016–4219; Directorate Identifier 2015–NM–169–AD.

(a) Comments Due Date

We must receive comments by April 22, 2016.

(b) Affected ADs

None.

(c) Applicability

This AD applies to all The Boeing Company Model 777–200, 777–200LR, 777–300, 777–300ER, and 777F series airplanes, certificated in any category, excluding line number 1165 and subsequent.

(d) Subject

Air Transport Association (ATA) of America Code 28, Fuel.

(e) Unsafe Condition

This AD was prompted by reports of latently failed fuel shutoff valves discovered during fuel filter replacement. We are issuing this AD to prevent latent failure of the fuel shutoff valve to the engine. This valve failure, if not prevented, could result in the inability to terminate fuel flow to the engine, which in case of an engine fire, could lead to wing failure.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Part Replacement

(1) For airplanes having Airplane Information Management System (AIMS) 1 installed: Within 24 months after the

effective date of this AD, install new engine fuel spar motor operated valve (MOV) actuators having part number (P/N) MA30A1017, in accordance with the Accomplishment Instructions of Boeing Service Bulletin 777–28A0034, Revision 3, dated September 25, 2015.

(2) For airplanes having AIMS 2, Blockpoint Version 16 or earlier installed: Within 24 months after the effective date of this AD, do the actions in paragraph (g)(2)(i) or (g)(2)(ii) of this AD.

(i) Install new engine fuel spar MOV actuators having P/N MA30A1017, in accordance with the Accomplishment Instructions of Boeing Service Bulletin 777–28A0034, Revision 3, dated September 25, 2015.

(ii) Install AIMS 2, Blockpoint Version 17 or later, in accordance with the Accomplishment Instructions of Boeing Service Bulletin 777–31–0227, Revision 1, dated August 12, 2015.

(h) Credit for Previous Actions

This paragraph provides credit for actions required by paragraph (g)(2)(ii) of this AD, if those actions were performed before the effective date of this AD using Boeing Special Attention Service Bulletin 777–31–0227, dated November 7, 2014, which is not incorporated by reference in this AD.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Seattle Aircraft Certification Office (ACO) FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the ACO, send it to the attention of the person identified in paragraph (j)(1) of this AD. Information may be emailed to: *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by the Boeing Commercial Airplanes Organization Designation Authorization (ODA) that has been authorized by the Manager, Seattle ACO, to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

(4) For service information that contains steps that are labeled as Required for Compliance (RC), the provisions of paragraphs (i)(4)(i) and (i)(4)(ii) of this AD apply.

(i) The steps labeled as RC, including substeps under an RC step and any figures identified in an RC step, must be done to comply with the AD. An AMOC is required for any deviations to RC steps, including substeps and identified figures.

(ii) Steps not labeled as RC may be deviated from using accepted methods in accordance with the operator's maintenance or inspection program without obtaining approval of an AMOC, provided the RC steps, including substeps and identified figures, can still be done as specified, and the airplane can be put back in an airworthy condition

(j) Related Information

(1) For more information about this AD, contact David Lee, Aerospace Engineer, Propulsion Branch, ANM–140S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: 425–917–6497; fax: 425–917–6590; email: *david.a.lee@faa.gov.*

(2) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P. O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone 206–544–5000, extension 1; fax 206–766–5680; Internet *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

Issued in Renton, Washington, on February 25, 2016.

Dionne Palermo,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2016–04682 Filed 3–7–16; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2015–0935; Directorate Identifier 2014–NM–243–AD]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Supplemental notice of proposed rulemaking (SNPRM); reopening of comment period.

SUMMARY: We are revising an earlier proposed airworthiness directive (AD) for certain The Boeing Company Model 747–100, 747–100B, 747–100B SUD, 747–200B, 747–200C, 747–200F, 747–300, 747–400, 747–400D, 747–400F, 747SR, and 747SP series airplanes. The notice of proposed rulemaking (NPRM) proposed to require replacing the wire bundles inside the electrical conduit of the forward and aft boost pumps of the numbers 1 and 4 main fuel tanks with new, improved wire bundles inserted into conduit liners. The NPRM was prompted by several reports of chafing of the wire bundles inside the electrical conduit of the forward and aft boost pumps of the numbers 1 and 4 main fuel tanks due to high vibration. These wire bundles can chafe through the wire sleeving into the insulation, exposing the wire conductors. This action revises the NPRM by adding a revision to the maintenance or inspection program, as applicable, to include critical design configuration control limitations (CDCCL) for the fuel boost pump wiring. We are proposing this SNPRM to prevent chafing of the wire bundles and subsequent arcing between the wiring and the electrical conduit creating an ignition source in the fuel tanks, which could result in a fire and consequent fuel tank explosion. Since these actions impose an additional burden over that proposed in the NPRM, we are reopening the comment period to allow the public the chance to comment on these proposed changes.

DATES: We must receive comments on this SNPRM by April 22, 2016.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this SNPRM, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P. O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone: 206–544–5000, extension 1; fax: 206–766–5680; Internet: *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221. Boeing Alert Service Bulletin 747–28A2306, dated October 2, 2014, is also available on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2015–0935.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://*

www.regulations.gov by searching for and locating Docket No. FAA–2015–0935; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (phone: 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Tung Tran, Aerospace Engineer, Propulsion Branch, ANM–140S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: 425–917–6505; fax: 425–917–6590; email: *tung.tran@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2015–0935; Directorate Identifier 2014–NM–243–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

We issued an NPRM to amend 14 CFR part 39 by adding an AD that would apply to certain The Boeing Company Model 747–100, 747–100B, 747–100B SUD, 747–200B, 747–200C, 747–200F, 747–300, 747–400, 747–400D, 747–400F, 747SR, and 747SP series airplanes. The NPRM published in the **Federal Register** on May 1, 2015 (80 FR 24850) (''the NPRM''). The NPRM proposed to require replacing the wire bundles inside the electrical conduit of the forward and aft boost pumps of the numbers 1 and 4 main fuel tanks with new, improved wire bundles inserted into conduit liners.

Actions Since the NPRM was Issued

Since we issued the NPRM, we have determined that it is necessary to revise the NPRM by adding a revision to the maintenance or inspection program, as applicable, to include critical design configuration control limitations (CDCCL) for the fuel boost pump wiring.

Related AD

AD 2011–15–03, Amendment 39–16750 (76 FR 41659, July 15, 2011) (''AD 2011–15–03''), superseded AD 97–26–07, Amendment 39–10250 (62 FR 65352, December 12, 1997), and requires repetitive inspections to detect damage of the sleeving and wire bundles of the boost pumps of the numbers 1 and 4 main fuel tanks, and of the auxiliary tank jettison pumps (if installed); replacement of any damaged sleeving with new sleeving; and repair or replacement of any damaged wires with new wires. For airplanes on which any burned wires are found, AD 2011–15–03 also requires an inspection to detect damage of the conduit, and replacement of any damaged conduit with a serviceable conduit. AD 2011–15–03 reduced the initial compliance time and repetitive inspection interval in AD 97–26–07. AD 2011–15–03 was prompted by fleet information indicating that the repetitive inspection interval in AD 97–26–07 was too long because excessive chafing of the sleeving continued to occur much earlier than expected between scheduled inspections. Accomplishing the replacement specified in this proposed AD would terminate the inspections required by paragraphs (g), (h), and (n) of AD 2011–15–03.

Comments

We gave the public the opportunity to comment on the NPRM. The following presents the comments received on the NPRM and the FAA's response to each comment.

Support for the NPRM

Boeing concurred with the contents of the NPRM.

Request To Withdraw the NPRM

UPS recommended that we withdraw the NPRM so that UPS can continue doing the inspections required by AD 2011–15–03. UPS stated that it has been inspecting the forward and aft boost pump wire bundles and sleeving since 2007 per the requirements in AD 2011–15–03, and is satisfied with the current inspection, which detects signs of wear before major damage occurs. UPS added that the wire bundle replacement in this NPRM is a burden to the airlines, without adding safety to the boost pump or airplane fuel system.

We do not agree with the commenter's request to withdraw the NPRM. We agree that the inspection required by AD 2011–15–03 is likely to detect signs of wear before major damage occurs, but the potential for an ignition source inside the fuel tank due to the single failure condition still exists. The manufacturer has now developed an improved wire bundle installation that eliminates the single failure condition. We have determined that installation of the improved design is required to eliminate the need for periodic maintenance and inspections in order to ensure safety.

Request To Change Paragraph (g) of the Proposed AD (in the NPRM)

United Airlines (United) asked that paragraph (g) of the proposed AD (in the NPRM) be changed to add paragraphs (g), (h), (i), (j), and (k) of AD 2011–15–03, to the language which terminates the repetitive inspections required by paragraph (n) of AD 2011–15–03. United stated that those paragraphs are also terminated after doing the wire bundle replacement required by paragraph (g) of the proposed AD (in the NPRM).

We agree to add paragraphs (g) and (h) of AD 2011–15–03, to the terminating action language specified in paragraph (g) of this proposed AD, because the replacement required by this proposed AD would terminate the inspections required by paragraphs (g) and (h) of AD 2011–15–03. However, paragraphs (i), (j), and (k) of AD 2011–15–03 are on-condition corrective actions, which must be done depending on the findings during any inspection required by paragraph (g) or (h) of AD 2011–15–03. Therefore, we have not referenced paragraphs (i), (j), and (k) of AD 2011–15–03 in paragraph (g) of this proposed AD.

Request To Add AWL Items

United stated that incorporating airworthiness limitation (AWL) tasks 28–AWL–24 (747 CL Certification Maintenance Requirements) and 28–AWL–35 (747–400 Maintenance Planning Data) should also be required by the NPRM.

We agree that this proposed AD should include revising the maintenance or inspection program, as applicable, by incorporating the CDCCL tasks related to accomplishing Boeing Alert Service Bulletin 747–28A2306, dated October 2, 2014; therefore, we have added new paragraphs (h) and (i) to this proposed AD to include those requirements. We have redesignated subsequent paragraphs accordingly.

Related Service Information Under 1 CFR Part 51

We reviewed the following service information:

- Boeing Alert Service Bulletin 747–28A2306, dated October 2, 2014. The service information describes procedures for replacing the wire bundles of the electrical conduit inside the electrical conduit of the forward and aft boost pumps of the numbers 1 and 4 main fuel tanks.
- AWL No. 28–AWL–24, ''Fuel Boost Pump Wires In Conduit Installation—In Fuel Tank,'' of Sub-section C.1, ''Fuel Tank Ignition Prevention,'' of Section C., ''Airworthiness Limitations—Systems,'' of the Boeing 747–100/200/300/SP Airworthiness Limitations (AWLs) and Certification Maintenance Requirements (CMRs) Document D6–13747–CMR, Revision June 2014. The service information describes a CDCCL for the fuel boost pump wiring.
- AWL No. 28–AWL–35, ''Fuel Boost Pump Wires In Conduit Installation—In Fuel Tank,'' of Sub-section B.1, ''Fuel System Ignition Prevention,'' of Section B, ''Airworthiness Limitations (AWLs)—Systems,'' of Section 9, Airworthiness Limitations (AWLs) and Certification Maintenance Requirements (CMRs), of Boeing 747–400 Maintenance Planning Data (MPD) Document D621U400–9, Revision June 2014. The service information describes a CDCCL for the fuel boost pump wiring.

This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

We are proposing this SNPRM because we evaluated all the relevant information and determined the unsafe condition described previously is likely to exist or develop in other products of the same type design. Certain changes described above expand the scope of the NPRM (80 FR 24850, May 1, 2013). As a result, we have determined that it is necessary to reopen the comment period to provide additional opportunity for the public to comment on this SNPRM.

Proposed Requirements of This SNPRM

This SNPRM would require accomplishing the actions specified in Boeing Alert Service Bulletin 747–28A2306, dated October 2, 2014, described previously. This SNPRM would also require revising the maintenance or inspection program, as applicable, to include CDCCLs for the fuel boost pump wiring.

This AD requires revisions to certain operator maintenance documents to include new actions (*e.g.,* inspections) and CDCCLs. Compliance with these actions and CDCCLs is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by this proposed AD, the operator may not be able to accomplish the actions described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance according to paragraph (j) of this AD. The request should include a description of changes to the required actions that will ensure the continued damage tolerance of the affected structure.

Notwithstanding any other maintenance or operational requirements, components that have been identified as airworthy or installed on the affected airplanes before accomplishing the revision of the airplane maintenance or inspection program specified in this proposed AD do not need to be reworked in accordance with the CDCCLs. However, once the airplane maintenance or inspection program has been revised as required by this proposed AD, future maintenance actions on these components must be done in accordance with the CDCCLs.

Costs of Compliance

We estimate that this proposed AD affects 176 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Replacement	Up to 53 work-hours × $85 per hour = $4,505.	$4,600	Up to $9,105	Up to $1,602,480.
Revise maintenance or inspection program.	1 work-hour × $85 per hour = $85	0	$85	$14,960.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979),

(3) Will not affect intrastate aviation in Alaska, and

(4) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator,

the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

The Boeing Company: Docket No. FAA–2015–0935; Directorate Identifier 2014–NM–243–AD.

(a) Comments Due Date

We must receive comments by April 22, 2016.

(b) Affected ADs

This AD affects AD 2011–15–03, Amendment 39–16750 (76 FR 41659, July 15, 2011).

(c) Applicability

This AD applies to The Boeing Company Model 747–100, 747–100B, 747–100B SUD, 747–200B, 747–200C, 747–200F, 747–300, 747–400, 747–400D, 747–400F, 747SR, and 747SP series airplanes, certificated in any category, as identified in Boeing Alert Service Bulletin 747–28A2306, dated October 2, 2014.

(d) Subject

Air Transport Association (ATA) of America Code 28, Fuel.

(e) Unsafe Condition

This AD was prompted by several reports of chafing of the wire bundles inside the electrical conduit of the forward and aft boost pumps of the numbers 1 and 4 main fuel tanks due to high vibration. These wire bundles can chafe through the wire sleeving into the insulation, exposing the wire conductors. We are issuing this AD to prevent chafing of the wire bundles and subsequent arcing between the wiring and the electrical conduit creating an ignition source in the fuel tanks, which could result in a fire and consequent fuel tank explosion.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Replacement

Within 60 months after the effective date of this AD: Replace the wire bundles inside the electrical conduit of the forward and aft boost pumps of the numbers 1 and 4 main fuel tanks with new, improved wire bundles inserted into conduit liners, in accordance with the Accomplishment Instructions of Boeing Alert Service Bulletin 747–28A2306, dated October 2, 2014. Accomplishing the replacement required by this paragraph terminates the inspections required by paragraphs (g), (h), and (n) of AD 2011–15–03, Amendment 39–16750 (76 FR 41659, July 15, 2011).

(h) Maintenance or Inspection Program Revision

Within 180 days after the effective date of this AD, revise the maintenance or inspection program, as applicable, to incorporate critical design configuration control limitation (CDCCL) Task AWL No. 28–AWL–24, ''Fuel Boost Pump Wires In Conduit Installation—In Fuel Tank,'' of Sub-section C.1, ''Fuel Tank Ignition Prevention,'' of Section C., ''Airworthiness Limitations—Systems,'' of the Boeing 747–100/200/300/SP Airworthiness Limitations (AWLs) and Certification Maintenance Requirements (CMRs) Document D6–13747–CMR, Revision June 2014; or CDCCL Task No. AWL No. 28–AWL–35, ''Fuel Boost Pump Wires In Conduit Installation—In Fuel Tank,'' of Sub-section B.1, ''Fuel System Ignition Prevention,'' of Section B, ''Airworthiness Limitations (AWLs)—Systems,'' of Section 9, Airworthiness Limitations (AWLs) and Certification Maintenance Requirements (CMRs), of Boeing 747–400 Maintenance Planning Data (MPD) Document D621U400–9, Revision June 2014; as applicable.

(i) No Alternative Actions, Intervals, and/or CDCCLs

After accomplishing the revision required by paragraph (h) of this AD, no alternative actions (*e.g.,* inspections), intervals, and/or CDCCLs may be used unless the actions, intervals, and/or CDCCLs are approved as an alternative method of compliance (AMOC) in accordance with the procedures specified in paragraph (j) of this AD.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Seattle Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the ACO, send it to the attention of the person identified in paragraph (k)(1) of this AD. Information may be emailed to: *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by the Boeing Commercial Airplanes Organization Designation Authorization (ODA) that has been authorized by the Manager, Seattle ACO, to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

(k) Related Information

(1) For more information about this AD, contact Tung Tran, Aerospace Engineer, Propulsion Branch, ANM–140S, FAA, Seattle ACO, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: 425–917–6505; fax: 425–917–6590; email: *tung.tran@faa.gov.*

(2) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P.O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; phone: 206–544–5000, extension 1; fax: 206–766–5680; Internet: *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

Issued in Renton, Washington, on February 18, 2016.

Dorr M. Anderson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2016–04681 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2016–4220; Directorate Identifier 2015–NM–076–AD]

RIN 2120–AA64

Airworthiness Directives; BAE Systems (Operations) Limited Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to supersede Airworthiness Directive (AD) 2011–24–06, for all BAE Systems (Operations) Limited Model Avro 146–RJ series airplanes. AD 2011–24–06 currently requires revising the maintenance program to incorporate life limits for certain items, adding new and more restrictive inspections to detect fatigue cracking in certain structures, and adding fuel system critical design configuration control limitations (CDCCLs) to prevent ignition sources in the fuel tanks. AD 2011–24–06 also currently requires modifying the main fittings of the main landing gear (MLG) and revising the maintenance program to incorporate new life limits on MLG up-locks and door up-locks and other MLG components. Since we issued AD 2011–24–06, we have determined that new or revised structural inspection requirements are necessary. This proposed AD would require revising the maintenance or inspection program, as applicable, to incorporate new or revised structural inspection requirements. We are proposing this AD to detect and correct fatigue cracking of

certain structural elements, which could adversely affect the structural integrity of the airplane.

DATES: We must receive comments on this proposed AD by April 22, 2016.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal: Go to http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, contact BAE Systems (Operations) Limited, Customer Information Department, Prestwick International Airport, Ayrshire, KA9 2RW, Scotland, United Kingdom; telephone +44 1292 675207; fax +44 1292 675704; email *RApublications@baesystems.com;* Internet *http://www.baesystems.com/Businesses/RegionalAircraft/index.htm.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4220; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Todd Thompson, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, WA 98057–3356; telephone: 425–227–1175; fax: 425–227–1149.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2016–4220; Directorate Identifier 2015–NM–076–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD based on those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

On November 8, 2011, we issued AD 2011–24–06, Amendment 39–16870 (76 FR 73477, November 29, 2011) (''AD 2011–24–06''). AD 2011–24–06 requires actions intended to address an unsafe condition on all BAE Systems (Operations) Limited Model Avro 146–RJ series airplanes.

Since we issued 2011–24–06, Amendment 39–16870 (76 FR 73477, November 29, 2011), we have determined that new or revised structural inspection requirements are necessary.

The European Aviation Safety Agency (EASA), which is the Technical Agent for the Member States of the European Union, has issued EASA Airworthiness Directive 2014–0071, dated March 19, 2014 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for all BAE Systems (Operations) Limited Model Avro 146–RJ series airplanes. The MCAI states:

> The BAe 146/AVRO 146–RJ Aircraft Maintenance Manual (AMM) includes the Chapters as listed in Appendix 1 of this [EASA] AD. Compliance with these chapters has been identified as a mandatory action for continued airworthiness and EASA AD 2012–0004 [*http://ad.easa.europa.eu/blob/easa_ad_2012_0004_superseded.pdf/AD_2012-0004_1*] was issued to require operators to comply with those instructions.
>
> Since that [EASA] AD was issued, BAE Systems (Operations) Ltd revised the AMM (Revision 107), introducing a new defined life limit for the Fire Bottle Cartridge Firing Unit into Chapter 05–10–15. Subsequently, Revision 108 of the AMM introduced in Chapter 05–20–00 inspection tasks for repairs applied to fatigue critical structures and also introduced a new Chapter 05–20–07 to provide Structural Repair Manual (SRM) references for these tasks, applicable to repairs accomplished after the publication of AMM Revision 108. Finally, AMM Revision 111 introduced safe life limitations into Chapter 05–10–15 for rollers of main landing gear and door up-locks.
>
> Furthermore, Section 6 of the Maintenance Review Board Report (MRBR) Document MRB 146–01, Issue 2, Revision 18 was published (as referenced in Chapter 05–20–01 of the AMM) to correct discrepancies in inspection tasks for a number of Structurally Important Items (SIIs). Grace periods for these revised inspection tasks are included in BAE Systems (Operations) Ltd Inspection Service Bulletin (ISB) ISB.53–237.
>
> Failure to comply with the new and more restrictive tasks and limitations referenced above could result in an unsafe condition.
>
> For the reasons described above, this [EASA] AD retains the requirements of EASA AD 2012–0004, which is superseded, and requires implementation of the maintenance tasks and/or airworthiness limitations as specified in the defined parts of Chapter 05 of the AMM at Revision 112.

The unsafe condition is fatigue cracking of certain structural elements, which could adversely affect the structural integrity of the airplane. You may examine the MCAI in the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4220.

FAA's Determination and Requirements of This Proposed AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with the State of Design Authority, we have been notified of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all pertinent information and determined an unsafe condition exists and is likely to exist or develop on other products of the same type design.

This proposed AD would require revisions to certain operator maintenance documents to include new actions (*e.g.,* inspections) and/or Critical Design Configuration Control Limitations (CDCCLs). Compliance with these actions and/or CDCCLs is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by this proposed AD, the operator may not be able to accomplish the actions described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance according to paragraph (k)(1) of this proposed AD. The request should include a description of changes

to the required actions that will ensure the continued damage tolerance of the affected structure.

Costs of Compliance

We estimate that this proposed AD affects 2 airplanes of U.S. registry.

The actions required by AD 2011–24–06 and retained in this proposed AD take about 3 work-hours per product, at an average labor rate of $85 per work-hour. Based on these figures, the estimated cost of the actions that are required by AD 2011–24–06 is $255 per product.

We also estimate that it would take about 1 work-hour per product to comply with the basic requirements of this proposed AD. The average labor rate is $85 per work-hour. Based on these figures, we estimate the cost of this proposed AD on U.S. operators to be $170, or $85 per product.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs,'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in ''Subtitle VII, Part A, Subpart III, Section 44701: General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979);

3. Will not affect intrastate aviation in Alaska; and

4. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Airworthiness Directive (AD) 2011–24–06, Amendment 39–16870 (76 FR 73477, November 29, 2011) (''AD 2011–24–06''), and adding the following new AD:

BAE Systems (Operations) Limited: Docket No. FAA–2016–4220; Directorate Identifier 2015–NM–076–AD.

(a) Comments Due Date

We must receive comments by April 22, 2016.

(b) Affected ADs

This AD replaces AD 2011–24–06, Amendment 39–16870 (76 FR 73477, November 29, 2011) (''AD 2011–24–06'').

(c) Applicability

This AD applies to BAE Systems (Operations) Limited Model Avro 146–RJ70A, 146–RJ85A, and 146–RJ100A airplanes, certificated in any category, all serial numbers.

(d) Subject

Air Transport Association (ATA) of America Code 05, Periodic Inspections.

(e) Reason

This AD was prompted by a determination that new or revised structural inspection requirements are necessary. We are issuing this AD to detect and correct fatigue cracking of certain structural elements, which could adversely affect the structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Retained Airworthiness Limitations Revisions of the Shock Absorber Assemblies

This paragraph restates the requirements of paragraph (j) of AD 2011–24–06, with no changes. Within 90 days after January 3, 2012 (the effective date of AD 2011–24–06), revise the maintenance program, by incorporating Subject 05–10–15, ''Aircraft Equipment Airworthiness Limitations'' of Chapter 05, ''Time Limits/Maintenance Checks,'' of the BAE SYSTEMS (Operations) Limited BAe 146 Series/Avro 146–RJ Series AMM, Revision 104, dated April 15, 2011, to remove life limits on shock absorber assemblies, but not the individual shock absorber components, amend life limits on main landing gear (MLG) up-locks and door up-locks, and to introduce and amend life limits on MLG components. Accomplishing the actions required by paragraph (i) of this AD terminates the actions required by this paragraph.

(h) Retained No Alternative Actions, Intervals, and/or Critical Design Configuration Control Limitations (CDCCLs), With No Changes

This paragraph restates the requirements of paragraph (k) of AD 2011–24–06, with no changes. Except as specified in paragraph (i) of this AD: After accomplishing the revision required by paragraph (g) of this AD, no alternative actions (*e.g.,* inspections), intervals, and/or CDCCLs may be used, unless the actions, intervals, and/or CDCCLs are approved as an alternative method of compliance (AMOC) in accordance with the procedures specified in paragraph (k)(1) of this AD.

(i) New Requirement of this AD: Revise Maintenance Program or Inspection Program

Within 90 days after the effective date of this AD: Revise the maintenance or inspection program, as applicable to incorporate new and revised limitations, tasks, thresholds, and intervals using a method approved by the Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA. Accomplishing the actions required by this paragraph terminates the actions required by paragraph (g) of this AD.

Note 1 to paragraph (i) of this AD: An additional source of guidance for the actions specified in paragraph (i) of this AD can be found in BAe 146/AVRO 146–RJ Airplane Maintenance Manual, Revision 112, dated October 15, 2013.

Note 2 to paragraph (i) of this AD: An additional source of guidance for the actions specified in paragraph (i) of this AD can be found in Corrosion Prevention Control Program (CPCP) Document No. CPCP–146–01, Revision 4, dated September 15, 2010.

Note 3 to paragraph (i) of this AD: An additional source of guidance for the actions specified in paragraph (i) of this AD can be found in Supplemental Structural Inspections Document (SSID) Document No. SSID–146–01, Revision 2, dated August 15, 2012.

Note 4 to paragraph (i) of this AD: An additional source of guidance for the actions specified in paragraph (i) of this AD can be found in Maintenance Review Board Report Document No. MRB 146–01, Issue 2, Revision 19, dated August 2012.

Note 5 to paragraph (i) of this AD: An additional source of guidance for the actions specified in paragraph (i) of this AD can be found in BAE Systems (Operations) Limited Inspection Service Bulletin ISB.53–237, Revision 1, dated April 2, 2013.

(j) New Requirement of This AD: No Alternative Actions, Intervals, and CDCCLs

After accomplishment of the revision required by paragraph (i) of this AD, no alternative actions (*e.g.,* inspections), intervals, and CDCCLs may be used, unless the actions, intervals, and CDCCLs are approved as an AMOC in accordance with the procedures specified in paragraph (k)(1) of this AD.

(k) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Branch, ANM–116, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the International Branch, send it to ATTN: Todd Thompson, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, Washington 98057–3356; telephone: 425–227–1175; fax: 425–227–1149. Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office. The AMOC approval letter must specifically reference this AD.

(2) *Contacting the Manufacturer:* As of the effective date of this AD, for any requirement in this AD to obtain corrective actions from a manufacturer, the action must be accomplished using a method approved by the Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA; or the European Aviation Safety Agency (EASA); or BAE Systems (Operations) Limited's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(l) Related Information

(1) Refer to Mandatory Continuing Airworthiness Information (MCAI) EASA Airworthiness Directive 2014–0071, dated March 19, 2014, for related information. This MCAI may be found in the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4220.

(2) For service information identified in this AD, contact BAE Systems (Operations) Limited, Customer Information Department, Prestwick International Airport, Ayrshire, KA9 2RW, Scotland, United Kingdom; telephone +44 1292 675207; fax +44 1292 675704; email *RApublications@baesystems.com;* Internet *http://www.baesystems.com/Businesses/RegionalAircraft/index.htm.* You may view this service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

Issued in Renton, Washington, on February 29, 2016.

Michael Kaszycki,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2016–04932 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2016–4221; Directorate Identifier 2015–NM–167–AD]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for all The Boeing Company Model 767–200 and –300 series airplanes. This proposed AD was prompted by an evaluation by the design approval holder (DAH) indicating that the aft pressure bulkhead web to pressure chord joint is subject to widespread fatigue damage (WFD). This proposed AD would require repetitive high frequency eddy current (HFEC) inspections of the aft pressure bulkhead web, at fasteners common to the bulkhead web and pressure chord, around the entire circumference of the pressure chord for any crack, and repair of cracks. We are proposing this AD to detect and correct cracks in the aft pressure bulkhead web. Such cracking could result in the loss of structural integrity of the airplane.

DATES: We must receive comments on this proposed AD by April 22, 2016.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal: Go to http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P.O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone: 206–544–5000, extension 1; fax: 206–766–5680; Internet: *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221. It is also available on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4221.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4221; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (phone: 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Wayne Lockett, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office (ACO), 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: 425–917–6447; fax: 425–917–6590; email: *wayne.lockett@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about

this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2016–4221; Directorate Identifier 2015–NM–167–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

Structural fatigue damage is progressive. It begins as minute cracks, and those cracks grow under the action of repeated stresses. This can happen because of normal operational conditions and design attributes, or because of isolated situations or incidents such as material defects, poor fabrication quality, or corrosion pits, dings, or scratches. Fatigue damage can occur locally, in small areas or structural design details, or globally. Global fatigue damage is general degradation of large areas of structure with similar structural details and stress levels. Multiple-site damage is global damage that occurs in a large structural element such as a single rivet line of a lap splice joining two large skin panels. Global damage can also occur in multiple elements such as adjacent frames or stringers. Multiple-site-damage and multiple-element-damage cracks are typically too small initially to be reliably detected with normal inspection methods. Without intervention, these cracks will grow, and eventually compromise the structural integrity of the airplane, in a condition known as WFD. As an airplane ages, WFD will likely occur, and will certainly occur if the airplane is operated long enough without any intervention.

The FAA's WFD final rule (75 FR 69746, November 15, 2010) became effective on January 14, 2011. The WFD rule requires certain actions to prevent structural failure due to WFD throughout the operational life of certain existing transport category airplanes and all of these airplanes that will be certificated in the future. For existing and future airplanes subject to the WFD rule, the rule requires that DAHs establish a limit of validity (LOV) of the engineering data that support the structural maintenance program. Operators affected by the WFD rule may not fly an airplane beyond its LOV, unless an extended LOV is approved.

The WFD rule (75 FR 69746, November 15, 2010) does not require identifying and developing maintenance actions if the DAHs can show that such actions are not necessary to prevent WFD before the airplane reaches the LOV. Many LOVs, however, do depend on accomplishment of future maintenance actions. As stated in the WFD rule, any maintenance actions necessary to reach the LOV will be mandated by airworthiness directives through separate rulemaking actions.

In the context of WFD, this action is necessary to enable DAHs to propose LOVs that allow operators the longest operational lives for their airplanes, and still ensure that WFD will not occur. This approach allows for an implementation strategy that provides flexibility to DAHs in determining the timing of service information development (with FAA approval), while providing operators with certainty regarding the LOV applicable to their airplanes.

The FAA has received a report indicating that an evaluation by the DAH has indicated that the aft pressure bulkhead web to pressure chord joint is subject to WFD. This condition, if not corrected could result in cracks from the aft pressure bulkhead web to pressure chord joint and possible loss of structural integrity of the airplane.

Related Service Information Under 1 CFR part 51

We reviewed Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015. This service information describes procedures for repetitive high frequency eddy current (HFEC) inspections of all visible locations of the aft pressure bulkhead web, at fasteners common to the bulkhead web and pressure chord, and around the entire circumference of the pressure chord for any crack, and repair of cracks. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

We are proposing this AD because we evaluated all the relevant information and determined the unsafe condition described previously is likely to exist or develop in other products of the same type design.

Proposed AD Requirements

This proposed AD would require accomplishing the actions specified in the service information described previously, except as discussed under ''Differences Between this Proposed AD and the Service Information.'' For information on the procedures and compliance times, see this service information at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2016–4221.

Differences between This Proposed AD and the Service Information

Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015, specifies to contact the manufacturer for instructions on how to repair certain conditions, but this proposed AD would require repairing those conditions in one of the following ways:

- In accordance with a method that we approve; or
- Using data that meet the certification basis of the airplane, and that have been approved by the Boeing Commercial Airplanes Organization Designation Authorization (ODA) whom we have authorized to make those findings.

The applicability in this proposed AD is not limited to airplanes identified in Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015. That service information does not contain a comprehensive list of the airplanes that are subject to the identified unsafe condition. This proposed AD would therefore apply to all Model 767–200 and –300 series airplanes.

Costs of Compliance

We estimate that this proposed AD affects 296 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection	57 work-hours × $85 per hour = $4,845 per inspection cycle.	$0	$4,845	$1,434,120 per inspection cycle.

The size of any repair area needs to be determined before material and work-hour costs can be calculated. We have received no definitive data that would enable us to provide cost estimates for the on-condition actions specified in this proposed AD.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII: Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979),

(3) Will not affect intrastate aviation in Alaska, and

(4) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

The Boeing Company: Docket No. FAA–2016–4221; Directorate Identifier 2015–NM–167–AD.

(a) Comments Due Date

We must receive comments by April 22, 2016.

(b) Affected ADs

None.

(c) Applicability

This AD applies to all The Boeing Company Model 767–200 and –300 series airplanes, certificated in any category.

(d) Subject

Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Unsafe Condition

This AD was prompted by an evaluation by the design approval holder (DAH) indicating that the aft pressure bulkhead web to pressure chord joint is subject to widespread fatigue damage (WFD). We are issuing this AD to detect and correct cracks in the aft pressure bulkhead web to pressure chord joint which could result in the loss of structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Repetitive Inspections

Except as required by paragraph (h) of this AD, at the applicable time specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015, perform a surface high frequency eddy current (HFEC) inspection for cracking of the aft pressure bulkhead web, at fasteners common to the bulkhead web and pressure chord, around the entire circumference of the pressure chord, in accordance with the Accomplishment Instructions of Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015. For this AD, Group 2, Configuration 2, as specified in Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015, includes airplanes with the aft pressure bulkhead replaced as specified in Boeing Alert Service Bulletin 767–53A0267. Repeat the inspection thereafter at the applicable time specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015.

(h) Service Information Exception

Where Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015, specifies a compliance time ''after the original issue date of this service bulletin,'' this AD requires compliance within the specified compliance time after the effective date of this AD.

(i) Crack Repair

If any crack is found during any inspection required by paragraph (g) of this AD, before further flight, repair the crack using a method approved in accordance with the procedures specified in paragraph (j) of this AD. Although Boeing Alert Service Bulletin 767–53A0268, dated April 1, 2015, specifies to contact Boeing for repair instructions, and specifies that action as ''RC'' (Required for Compliance), this AD requires repair as specified in this paragraph. Installation of a repair terminates the inspections required by paragraph (g) of this AD in the area covered by the repair only.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Seattle Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the ACO, send it to the attention of the person identified in paragraph (k)(1) of this AD. Information may be emailed to: *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by the Boeing

Commercial Airplanes Organization Designation Authorization (ODA) that has been authorized by the Manager, Seattle ACO to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane and the approval must specifically refer to this AD.

(4) Except as required by paragraph (i) of this AD: For service information that contains steps that are labeled as RC, the provisions of paragraphs (j)(4)(i) and (j)(4)(ii) apply.

(i) The steps labeled as RC, including substeps under an RC step and any figures identified in an RC step, must be done to comply with the AD. An AMOC is required for any deviations to RC steps, including substeps and identified figures.

(ii) Steps not labeled as RC may be deviated from using accepted methods in accordance with the operator's maintenance or inspection program without obtaining approval of an AMOC, provided the RC steps, including substeps and identified figures, can still be done as specified, and the airplane can be put back in an airworthy condition.

(k) Related Information

(1) For more information about this AD, contact Wayne Lockett, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle ACO, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: 425–917–6447; fax: 425–917–6590; email: *wayne.lockett@faa.gov*.

(2) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P. O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone: 206–544–5000, extension 1; fax: 206–766–5680; Internet: *https://www.myboeingfleet.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

Issued in Renton, Washington, on February 29, 2016.

Michael Kaszycki,

Acting Manager, Transport Airplane Directorate Aircraft Certification Service.

[FR Doc. 2016–04931 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF STATE

22 CFR Part 41

[Public Notice: 9458]

RIN 1400–AD30

Visas: Documentation of Nonimmigrants Under the Immigration and Nationality Act, as Amended

AGENCY: Department of State.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department of State proposes to reinstate a temporarily suspended amendment to its visa regulations to clarify procedures for waiver of documentary requirements due to an unforeseen emergency for nonimmigrants seeking admission to the United States.

DATES: Comments must be received on or before May 9, 2016.

ADDRESSES: Internet: You may view this proposed rule and submit your comments by visiting the Regulations.gov Web site at *www.regulations.gov,* and searching for docket number DOS–2016–0010.

FOR FURTHER INFORMATION CONTACT: Lauren A. Boquin, Legislation and Regulations Division, Legal Affairs, Office of Visa Services, Bureau of Consular Affairs, Department of State, 600 19th St NW., Washington, DC 20006 (202) 485–7638.

SUPPLEMENTARY INFORMATION:

Background

This rulemaking proposes to reinstate a 1999 regulatory amendment that was invalidated by court order in *United Airlines, Inc.* v. *Brien,* 588 F.3d 158 (2d Cir. 2009).

Pursuant to Section 212(a)(7)(B)(i) of the Immigration and Nationality Act (INA), a nonimmigrant is inadmissible to the United States if he or she does not present an unexpired passport and valid visa at the time of application for admission. 8 U.S.C. 1182(a)(7)(B)(i). Either or both of these requirements may be waived by the Secretary of Homeland Security and the Secretary of State, acting jointly, in specified situations, as provided in INA section 212(d)(4) (8 U.S.C. 1182(d)(4)). One circumstance in which this requirement may be waived is when a nonimmigrant is unable to present a valid visa or unexpired passport due to an unforeseen emergency. In accordance with INA section 212(d)(4) (8 U.S.C. 1182(d)(4)), the Department of State and the Department of Homeland Security have consulted and are acting jointly to propose amendments to 8 CFR 212.1 and 22 CFR 41.2.

Former Regulations

The Department of State and the former Immigration and Naturalization Service (INS) published parallel regulations in 1994 to consolidate and simplify procedures for processing waivers of documentary requirements in cases of emergency circumstances. INS amended its regulation in 1996, preserving its authority to impose fines on carriers for transporting nonimmigrants who did not present a valid visa and passport, even in cases where the INS granted a waiver. In 1999, the Department of State published a regulation to accompany the INS amendment, also allowing the INS to fine carriers who transported individuals who later received waivers of the visa and passport requirement. In a 2009 decision, the U.S. Court of Appeals for the Second Circuit found the 1999 State Department amendment invalid as it lacked joint action and was not promulgated with a period for public notice and comment. Accordingly, the Department of State and DHS have consulted and are acting jointly to propose reinstating the amendments.

Because of the court's ruling, the 1994 rule is in effect until the Department of State issues a final rule. The 1994 version of the text, which is available to the public through the Government Printing Office, stipulated that in cases of unforeseen emergencies, a visa and passport are not required of an alien if, either prior to the alien's embarkation abroad or upon arrival at a port of entry, the responsible district director of the Immigration and Naturalization Service in charge of the port of entry concludes that the alien is unable to present the required documents because of an unforeseen emergency. The 1994 rule also stipulated that any waiver of the visa or passport requirement may be granted by the INS district director pursuant to INA 212(d)(4)(A) without the prior concurrence of the Department of State in each case in which the district director concludes that the alien's claim of emergency circumstances is legitimate and bona fide and that approval of the waiver would be appropriate under all of the attendant facts and circumstances.

The Department of Homeland Security is proposing a parallel Notice of Proposed Rulemaking to amend 8 CFR 212.1(g), published in today's **Federal Register**.

Regulatory Findings

A. Administrative Procedure Act

The Department is publishing this notice of proposed rulemaking with a 60-day period of notice and comment.

B. Regulatory Flexibility Act/Executive Order 13272: Small Business

The Department of State has reviewed this regulation and certifies that this rule will not have a significant economic impact on a substantial number of small entities.

C. The Unfunded Mandates Reform Act of 1995

Section 202 of the Unfunded Mandates Reform Act of 1995, Public Law 104–4, 109 Stat. 48, 2 U.S.C. 1532,

generally requires agencies to prepare a statement before proposing any rule that may result in an annual expenditure of $100 million or more by State, local, or tribal governments, or by the private sector. This rule will not result in any such expenditure, nor will it significantly or uniquely affect small governments.

D. The Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by 5 U.S.C. 804, for purposes of congressional review of agency rulemaking under the Small Business Regulatory Enforcement Fairness Act of 1996. This rule will not result in an annual effect on the economy of $100 million or more; a major increase in costs or prices; or adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based companies to compete with foreign-based companies in domestic and import markets.

E. Executive Order 12866

The Department of State does not assess or collect fines under INA section 273. Neither this proposed Department of State rule, nor prior versions of this regulation, address fines against carriers. However, the November 20, 2009, opinion from the United States Circuit Court of Appeals for the Second Circuit requires joint rulemaking by the Department of State and DHS for the DHS rule to take effect. United Airlines, Inc. v. Brien, 588 F.3d 158, 179 (2d Cir. 2009). For a full economic analysis of the jointly proposed DHS rule, including Regulatory Flexibility and Regulatory Impact Analyses, see the U.S. Customs and Border Protection Notice of Proposed Rulemaking for 8 CFR 212.1(g), RIN 1651–AA97.

F. Executive Order 13563

The Department of State has considered this rule in light of Executive Order 13563 and affirms that this regulation is consistent with the guidance therein.

G. Executive Orders 12372 and 13132: Federalism

This regulation will not have substantial direct effects on the States, on the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. Nor will the rule have federalism implications warranting the application of Executive Orders No. 12372 and No. 13132.

H. Executive Order 13175—Consultation and Coordination With Indian Tribal Governments

The Department has determined that this rulemaking will not have tribal implications, will not impose substantial direct compliance costs on Indian tribal governments, and will not pre-empt tribal law. Accordingly, the requirements of section 5 of Executive Order 13175 do not apply to this rulemaking.

I. Paperwork Reduction Act

This rule does not impose or revise information collections subject to the provisions of the Paperwork Reduction Act, 44 U.S.C., Chapter 35.

List of Subjects in 22 CFR Part 41

Aliens, Foreign officials, Immigration, Passports and Visas, Students

Accordingly, for the reasons set forth in the preamble, the State Department proposes to amend 22 CFR part 41 as follows:

PART 41 VISAS: DOCUMENTATION OF NONIMMIGRANTS UNDER THE IMMIGRATION AND NATIONALITY ACT, AS AMENDED

■ 1. The authority citation for part 41 is revised to read as follows:

Authority: 22 U.S.C. 2651a; 8 U.S.C. 1104; Pub. L. 105–277, 112 Stat. 2681–795 through 2681–801; 8 U.S.C. 1185 note (section 7209 of Pub. L. 108–458, as amended by section 546 of Pub. L. 109–295).

■ 2. Section 41.2 is amended by revising paragraph (i) to read as follows:

§ 41.2 Exemption or Waiver by Secretary of State and Secretary of Homeland Security of passport and/or visa requirements for certain categories of nonimmigrants.

* * * * *

(i) *Individual cases of unforeseen emergencies.* Except as provided in paragraphs (a) through (h) and (j) through (l) of this section, all nonimmigrants are required to present a valid, unexpired visa and passport upon arrival in the United States. A nonimmigrant may apply for a waiver of the visa and passport requirement if, either prior to the nonimmigrant's embarkation abroad or upon arrival at a port of entry, the officer in charge of the port of entry concludes that the nonimmigrant is unable to present the required documents because of an unforeseen emergency. The DHS district director may grant a waiver of the visa or passport requirement pursuant to INA 212(d)(4)(A), without the prior concurrence of the Department of State, if the DHS district director concludes that the a nonimmigrant's claim of emergency circumstances is legitimate and that approval of the waiver would be appropriate under all of the attendant facts and circumstances.

* * * * *

Dated: February 24, 2016.

David T. Donahue,

Acting Assistant Secretary for Consular Affairs, Department of State.

[FR Doc. 2016–05136 Filed 3–7–16; 8:45 am]

BILLING CODE 4710–06–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Part 266

[Docket No FR–5881–P–01]

RIN 2502–AJ35

Section 542(c) Housing Finance Agencies Risk-Sharing Program: Revisions to Regulations

AGENCY: Office of the Assistant Secretary for Housing-Federal Housing Commissioner, HUD.

ACTION: Proposed rule.

SUMMARY: Through the Section 542(c) HFA Risk-Sharing program, HUD enters into risk-sharing agreements with State and local housing finance agencies (HFAs) so that HFAs can provide more insurance and credit for multifamily loans. This proposed rule would amend existing regulations for the program so that they better align with policies for other HUD programs, reflect current industry and HUD practices, and conform to statutory amendments. Additionally, this proposed rule would provide HUD with greater flexibility in operating the Section 542(c) HFA Risk-Sharing program 0s,over time, and would provide more flexibility for certain HFAs accepting a greater share of the risk of loss on mortgages insured under the program. This proposed rule would also update references and terminology that are now outdated and clarify certain provisions.

DATES: *Comment Due Date:* April 7, 2016.

ADDRESSES: Interested persons are invited to submit comments regarding this notice to the Regulations Division, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW., Room 10276, Washington, DC 20410–0500. Communications must refer to the above docket number and title. There are two methods for submitting public comments. All submissions must refer to the above docket number and title.

1. *Submission of Comments by Mail.* Comments may be submitted by mail to the Regulations Division, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW., Room 10276, Washington, DC 20410–0500.

2. *Electronic Submission of Comments.* Interested persons may submit comments electronically through the Federal eRulemaking Portal at *www.regulations.gov.* HUD strongly encourages commenters to submit comments electronically. Electronic submission of comments allows the commenter maximum time to prepare and submit a comment, ensures timely receipt by HUD, and enables HUD to make them immediately available to the public. Comments submitted electronically through the *www.regulations.gov* Web site can be viewed by other commenters and interested members of the public. Commenters should follow the instructions provided on that site to submit comments electronically.

Note: To receive consideration as public comments, comments must be submitted through one of the two methods specified above. Again, all submissions must refer to the docket number and title of this document.

No Facsimile Comments. Facsimile (FAX) comments are not acceptable.

Public Inspection of Public Comments. All properly submitted comments and communications submitted to HUD will be available for public inspection and copying between 8 a.m. and 5 p.m., weekdays, at the above address. Due to security measures at the HUD Headquarters building, an appointment to review the public comments must be scheduled in advance by calling the Regulations Division at 202–708–3055 (this is not a toll-free number). Individuals with speech or hearing impairments may access this number via TTY by calling the Federal Relay Service at 800–877–8339. Copies of all comments submitted are available for inspection and downloading at *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Diana Talios, Office of Multifamily Production, Office of Housing, Department of Housing and Urban Development, 451 7th Street SW., Room 6156, Washington, DC 20410; telephone number (202) 402–7125 (this is not a toll-free number). Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at 800–877–8339.

SUPPLEMENTARY INFORMATION:

I. Background

Section 542 of the Housing and Community Development Act of 1992 (12 U.S.C. 1707 1715z–22) (Section 542) directs HUD to carry out programs through the Federal Housing Administration (FHA) to demonstrate the effectiveness of providing new forms of Federal credit enhancement for multifamily loans. Originally enacted as a pilot program, the Section 542(c) HFA Risk-Sharing program was made a permanent multifamily insurance program by section 235 of title II of Public Law 106–377,[1] HUD's Fiscal Year 2001 appropriations act (FY 2001 HUD Appropriations Act).

The purpose of the Section 542(c) HFA Risk-Sharing program is to provide credit enhancement for mortgages of multifamily housing projects whose loans are underwritten, processed, serviced, and disposed of by HFAs. HUD and HFAs share in the risk of the mortgage, which enables HFAs to provide more insurance and credit for multifamily loans. Under the program, qualified State and local HFAs may originate and underwrite affordable housing loans including new construction, substantial rehabilitation, refinancing, and housing for the elderly. HFAs may elect to share from 10 to 90 percent of the loss on a loan with HUD. In the event of a claim, the HFA reimburses HUD pursuant to terms of the risk-sharing agreement.

HUD's regulations governing the Section 542(c) HFA Risk-Sharing program are set out in 24 CFR part 266. Part 266 was last updated in the year 2000 and is now outdated in certain respects.

II. This Proposed Rule

HUD proposes to revise 24 CFR part 266 in order to update the regulations, to better align them with current HUD policies and industry practices, and to provide HUD and certain HFAs with flexibility to operate the Section 542(c) HFA Risk-Sharing program more efficiently.

A. Conforming Amendments

This proposed rule would revise sections of part 266 to conform to Section 542(c), as it was amended by the FY 2001 HUD Appropriations Act. Specifically, this proposed rule would amend part 266 to remove references to the program being a pilot.

Additionally, this proposed rule would amend the definition of affordable housing in § 266.5 so that it more closely conforms to the statutory language of Section 542. Specifically, this proposed rule would amend the definition of ''affordable housing'' for the Section 542 HFA Risk-Sharing program to mean a project that meets the requirements for a qualified low-income housing project under section 42(g) of the Internal Revenue Code (26 U.S.C. title 26) (IRC).

Currently, § 266.5 specifies that affordable housing means a project in which 20 percent or more of the units are both rent-restricted and occupied by families whose income is 50 percent or less of the area median income as determined by HUD, with adjustments for household size, or in which 40 percent [2] or more of the units are both rent-restricted and occupied by families whose income is 60 percent or less of the area median income as determined by HUD, with adjustments for household size. The existing definition also says that a residential unit is rent-restricted if the gross rent with respect to such unit does not exceed 30 percent of the imputed income limitation applicable to such unit.

The regulatory language unnecessarily repeats what is already provided in statute. Section 542(c)(7) states that housing securing loans insured under the section qualifies as affordable only if the housing is occupied by very low-income families and bears rents not greater than the gross rent for rent-restricted residential units as determined under section 42(g)(2) of the IRC. Section 42(g) of the IRC provides qualifications for low-income housing projects to be eligible for a low-income housing tax credit. While the definition in Section 542 cross references only to IRC subsection 42(g)(2), the rent limits established in subsection (g)(2) can be understood only through a reading of IRC subsection (g) in its entirety as a result of internal cross references in the IRC statutory language. Because ''gross rent'' and ''supportive service'' are both defined in section 42(g) of the IRC, this proposed rule would remove the definitions of these two terms from § 266.5, but would include in the definition of ''affordable housing'' the provision currently in the ''gross rent'' definition that a utility allowance includes charges for the occupancy of a cooperative unit. The proposed regulatory change will remove unnecessary regulatory verbiage and simplify the part 266 regulations.

Further, § 266.210(b) of the existing regulations is outdated in that it provides that compliance with the

[1] Approved October 27, 2000.

[2] Twenty five percent in New York City as a result of section 142(d)(6) of the IRC establishing a special rule for projects located in a specified high cost housing area.

National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*) (NEPA) is the responsibility of the HUD Field Office or other responsible entity. However, Section 542(c)(9) of the Housing and Community Development Act of 1992, as amended by the Multifamily Housing Property Disposition Reform Act of 1994 (Pub. L. 103–233), provides that HUD may provide for assumption of its environmental review requirements. This proposed regulation thus moves the paragraph on NEPA compliance requirements from § 266.210, HUD-retained review functions, to a new section, § 266.217, titled ''Environmental review requirements.'' This proposed rule would also change the phrasing of the existing environmental review requirements to make it clear that Responsible Entities assume legal responsibility for environmental compliance, but HUD may make a finding in accordance with 24 CFR 58.11 (Legal capacity and performance) and may perform the environmental review itself under 24 CFR part 50 (Protection and enhancement of environmental quality). Relatedly, this proposed rule would revise § 266.300(b) and § 266.305(b), which describe HFA responsibilities, to reflect that the HFA has a responsibility to arrange for the environmental review.

This proposed rule would also amend certain sections of the regulations to conform to other HUD regulations. The proposed rule would revise § 266.215(e) to reflect that HFAs must follow Lead-Based Paint requirements in 24 CFR part 35, and it would also update § 266.220(b) to reflect HUD's equal access rule, which requires that HUD-assisted and HUD-insured housing be made available without regard to actual or perceived sexual orientation, gender identity, or marital status (See 77 FR 5662, February 3, 2012). Currently, § 266.220(b) states that the mortgagor must certify that it will not discriminate against any family because of the sex of the head of household. This proposed rule would update the section to state that the mortgagor must certify that it will provide housing without regard to sexual orientation, gender identity, or marital status, and will refrain from making improper inquiries, in accordance with 24 CFR 5.105(a)(2).

B. Updating Terminology

This proposed rule would update part 266 to eliminate references to outdated terminology. Specifically, §§ 266.100(a)(1), 266.110(a), and 266.120(d)(5) refer to HFAs that have or maintain a top tier designation. However, rating agencies no longer offer top tier ratings. Rather, current rating agency practice is to provide an issuer credit rating that evaluates the agency's capacity and willingness to meet its financial commitments. The proposed rule would replace requirements for HFAs to have top tier designation with requirements that they have an issuer rating of ''A'' or better. Additionally, § 266.505(b)(10) refers to the General Accounting Office, and this proposed rule would change this to reflect the current name of the agency: The Government Accountability Office.

C. Revisions To Provide Greater Flexibility

HUD proposes changing certain requirements to provide both HUD and HFAs that assume a larger share of the risk with greater flexibility in operating the Section 542(c) HFA Risk-Sharing program.

Under § 266.100(b), HFAs with Level II approval, that is, HFAs that assume less than 50% of the risk of loss on mortgages insured under the Section 542(c) HFA Risk-Sharing program, must use underwriting standards and loan terms and conditions approved by HUD. However, the regulations do not provide that HUD can revisit the approval if market conditions or risk standards change. Many of the standards used by HFAs with Level II approval have been in place for more than 20 years. This proposed rule would amend § 266.100(b) to provide that, every five years, HUD will recertify the underwriting standards, loan terms and conditions, and asset management and servicing procedures for HFAs with Level II approval, and may require changes to these procedures as a condition for continued approval. HUD's review would periodically benchmark Level II HFA underwriting standards against current FHA standards that are analogous to the appropriate FHA program. Additionally, § 266.305(a), which describes underwriting standards for HFAs accepting less than 50% of the risk, would refer to the revised § 266.100(b).

Similarly, this proposed rule would amend § 266.125(a), which describes actions that HUD may take against HFAs that do not comply with Section 542(c) HFA Risk-Sharing program requirements, to provide that one of the actions that HUD may take is to require the HFA to revise any or all of its underwriting, processing, or asset management policies as directed by the FHA Commissioner.

This proposed rule would provide HFAs that assume at least 50% of the risk of loss on mortgages insured under the Section 542(c) HFA Risk-Sharing program more flexibility in financing existing properties without substantial rehabilitation to preserve affordability by amending § 266.200(c). Currently, § 266.200(c) provides that HFAs may finance existing properties without substantial rehabilitation if the financing will result in the preservation of affordable housing, project occupancy is not less than 93 percent, the mortgage does not exceed an amount supportable by the lower of the units rents being collected under the rental assistance agreement or at similar unassisted projects in the market area, and the HUD-insured mortgage does not exceed the sum of the existing indebtedness, cost of refinancing, cost of repairs, and reasonable transaction costs. Additionally, HFAs that assume less than 50 percent of the risk may not refinance loans that had been in default within the 12 months prior to the application for refinancing. The proposed rule maintains these requirements, but eliminates the requirement that the HUD-insured mortgage may not exceed the sum of the existing indebtedness, cost of refinancing, cost of repairs, and reasonable transaction costs for HFAs that assume 50 percent or more of the risk. Permitting equity take-outs under certain conditions for refinance and acquisition transactions is a key preservation tool to ensure long-term affordability. This provision is also consistent with similar FHA programs, and industry practice.

In order to mitigate risk to FHA, ensure affordability of projects, and consistent with FHA's experience, this proposed rule would add additional requirements that all HFAs would have to meet in order to finance existing properties: Loans to be refinanced cannot have been in default in the 12 months prior to the date of application for refinancing, the owner must agree to renew the housing assistance payments (HAP) contract for a 20-year term, if applicable, existing and post-refinance HAP residual receipts must be set aside to be used to reduce future HAP payments, the property must be maintained as affordable housing for a period of at least 20 years, regardless of whether the loan is prepaid, and a capital needs assessment must be performed and funds escrowed for all necessary repairs and replacement reserves funded for future capital repairs.

Additionally, this proposed rule would provide HFAs that assume at least 50% of the risk of loss on Section 542(c) mortgages more flexibility by providing that certain loans need not be regularly amortizing. Section 266.410(e)

would be revised so that loans of HFAs that assume at least 50% of the risk would not need to be regularly amortizing if they have a minimum term of 17 years and HUD has approved the HFA's underwriting standards, loan terms and conditions, and asset management and servicing procedures. Non-fully amortizing (also known as ''balloon'') loans are not unusual multifamily lending options. The change will align the 542(c) program with conventional industry practices, particularly for Low Income Housing Tax Credits (LIHTC) transactions. Moreover, balloon loans with similar terms are typical in HUD's section 542(b) Risk Share program, under which HUD enters into reinsurance agreements with Fannie Mae, Freddie Mac, the Federal Housing Finance Board, and other Qualified Financial Institutions (QFIs).

Further, this proposed rule would revise § 266.620, which explains circumstances under which the contract of insurance would terminate. This proposed rule adds flexibility by providing that, in cases where an HFA or its successors commits fraud or makes a material misrepresentation, HUD may permit HFAs that assume more than 50% of the risk and have an issuer rating of ''A'' or better to indemnify HUD, or otherwise reimburse HUD in a manner acceptable to the Commissioner, for the full amount of the mortgage claim in lieu of the mortgage insurance contract being terminated. This change would provide flexibility for HFAs that assume more than 50% of the risk to participate in certain financing initiatives offered by HUD under the Section 542(c) HFA Risk-Sharing program, while protecting the FHA General and Special Risk Insurance Fund against losses.

D. Revisions To Reflect Current Program Practices

In addition to amending § 266.410(e) to provide more flexibility for certain HFAs, this proposed rule would clarify that the existing requirement that the mortgage must be fully amortizing does not apply to construction loans. Construction loans have typically been non-amortizing, interest-only loans since the inception of the program, and this is typical industry practice.

This proposed rule would also better reflect current program practices by removing § 266.10, entitled ''Allocations of assistance and credit subsidy.'' Section 266.10 currently provides that HUD will announce the availability of assistance under the Section 542(c) HFA Risk-Sharing program and invite qualified HFAs to submit an application. It also provides that credit subsidies will be obligated and allocated in accordance with outstanding HUD instructions. This section was relevant when the Section 542(c) HFA Risk-Sharing program was a pilot program with specific unit counts reserved for each participating HFA. Unit allocations and reservations of credit subsidy are no longer required because the program is a permanent insurance program.

Relatedly, this proposed rule would amend § 266.105(b), which says that applications from HFAs for approval to participate in the Section 542(c) HFA Risk-Sharing program will be submitted in response to a notice published in the **Federal Register**. In accordance with current practice, which reflects that the Section 542(c) HFA Risk-Sharing program is now permanent, this section would now state that applications may be submitted at any time, in the form and manner established by HUD.

This proposed rule would clarify that in certain circumstances, Housing for Older Persons projects, as described in 24 CFR part 100 subpart E, qualify as eligible projects under § 266.200. Housing providers should be aware that projects must comply with all program rules and the housing for older persons exemption to the Fair Housing Act (42 U.S.C. 3607(b); 24 CFR part 100 subpart E) in order to exclude families with children under 18. A housing facility insured under the Section 542 program may not invoke the housing for older persons exemption to exclude children if it also receives Federal financial assistance pursuant to a statute or program in which eligible families include children under the age of 18. For example, owners of projects that receive rental assistance under any of the Section 8 rental assistance programs are bound by the definition of ''families'' and ''elderly families'' in section 3(b)(3)(B) of the United States Housing Act of 1937 and in implementing regulations. Because these definitions explicitly include families with children, such projects are not eligible for the exemption. The housing for older persons exemption allows a housing community to exclude children under 18 years without violating the Fair Housing Act's prohibition against familial status discrimination. The Fair Housing Act prohibits, *inter alia,* familial status discrimination, which means one or more individuals who have not attained the age of 18 years being domiciled with (1) a parent or another person having legal custody of such individual or individuals or (2) the designee of such parent or other person having such custody, with the written permission of such parent or other person. The protections against familial status discrimination apply also to persons who are pregnant or who are in the process of securing legal custody of any individual who is not yet 18 years old. See 42 U.S.C. 3602(k).

The housing for older persons exemption may be invoked if the housing is either provided under a State or Federal program that the Secretary of HUD determines is specifically designed and operated to assist elderly persons, or, intended for and solely occupied by, persons who are 62 years old or older, or, intended and operated for persons who are 55 years of age or older where at least 80 percent of the occupied units are occupied by at least one person who is at least 55 years old, the housing facility publishes and adheres to policies and procedures that demonstrate the intent to serve persons 55 years old and older, and, the housing facility complies with HUD's rules for verification of occupancy. See 42 U.S.C. 3607(b) and 24 CFR 100.300 through 100.307.

In order to qualify for the housing for older persons exemption, State or Federal programs must be determined by the Secretary to be ''specifically designed and operated to assist elderly persons (as defined in the State or Federal program).'' See 42 U.S.C. 3607(b)(2)(A); 24 CFR 100.302. HUD, however, has never designated one of its own programs as housing for older persons under this exemption.

Relatedly, the rulemaking proposes to add a clause to the description of elderly projects, at § 266.200, specifying that an elderly family includes families with minor children. This is to distinguish such projects from those that qualify for and claim an exemption from the Fair Housing Act's prohibition against familial status discrimination at 42 U.S.C. 3607(b)(2).

Another change this proposed rule would make is to § 266.420(b)(4), which currently requires that, in periodic advances cases, HFAs provide a certification that periodic advances were made proportionate to construction progress as part of their closing dockets. However, § 266.310, entitled, ''Insurance of advances or insurance upon completion; applicability of requirements,'' does not require periodic advances to be made proportionate to construction progress. This proposed rule therefore revises § 266.420(b)(4) to remove the requirement that periodic advances be proportionate to construction progress, and instead requires that, as part of their closing documents, in periodic advances cases HFAs provide

certification that the advances were made in accordance with the mortgage pursuant to § 266.310.

This proposed rule would also revise § 266.650, Items deducted from total loss, to clarify that where a full claim follows a partial payment of claim by HUD, that partial payment of claim is considered an amount received by the HFA that will be deducted from the total loss to be shared by HUD and the HFA. The existing regulatory language does not explicitly provide this.

Another change this proposed rule would make to reflect current program practices is to clarify that where HUD may direct or review an HFA's underwriting standards and loan terms and conditions, it may also direct or review that HFA's asset management and servicing procedures. Thus, this proposed rule adds references to ''asset management and servicing procedures'' throughout, and adds a new paragraph to § 266.500 that explains that asset management and servicing procedures of any HFA electing to take less than 50 percent of the risk on certain projects are subject to review, modification, and approval by HUD.

This proposed rule also makes changes for accuracy, such as deleting the parenthetical in § 266.100(b)(1) that suggests that Level I approval is where an HFA assumes a percentage of the risk of loss in ''(increments of 10 percent),'' because the risk percentages are not limited to 10 percent increments.

E. Aligning Section 542(c) With Other FHA Programs

Section 266.200(d) currently provides that projects receiving Section 8 rental subsidies or other rental subsidies may be insured only if the mortgage does not exceed an amount supportable by the lower of contract rents under the rental assistance agreement or market rents. However, under HUD's Supportive Housing program, authorized under section 202 of the Housing Act of 1959 (12 U.S.C. 1701q), a project may be insured if the loan is underwritten to contract rents, regardless of market rents. This proposed rule would amend § 266.200(d) so that Supportive Housing program projects of HFAs assuming at least 50 percent of the risk of loss on mortgages insured under the Section 542(c) HFA Risk-Sharing program would be subject to the same underwriting standard as other Section 202 projects in that the loans may be underwritten to contract rents. A similar change is incorporated in new § 266.200(c)(7) for existing projects without substantial rehabilitation. These changes will better align requirements between HUD programs, thereby streamlining and facilitating program administration by HFAs, as well as HUD oversight.

FHA currently requires a National Loan Committee to approve all large loans under the Multifamily Accelerated Processing (MAP) Guide as a means of managing risk. Loans of HFAs that assume less than 50 percent of the risk of loss pose a similar risk to FHA as do MAP loans. Therefore, this proposed rule would amend § 266.305(a), establishing the underwriting standards for HFAs accepting less than 50 percent of the risk, to add a provision that large loans also require prior approval by the FHA Commissioner. What constitutes a large loan will be determined using the same process currently used by HUD for establishing large loan amounts in other FHA programs.

This proposed rule would revise § 266.200(b)(2), the explanation of substantial rehabilitation projects eligible for the Section 542(c) HFA Risk-Sharing program, so that substantial rehabilitation would occur when the scope of work to improve an existing project exceeds in aggregate cost a sum equal to the base per dwelling unit limit times the applicable high cost factor established by the Commissioner, or when the scope of work involves the replacement of two or more building systems. 'Replacement' is when the cost of replacement work exceeds 50% of the cost of replacing the entire system. The base per dwelling unit limit is $15,000 per unit for 2015, and will be adjusted annually based on the percentage change in the consumer price index. The rationale for the revision is twofold: The current definition of substantial rehabilitation as work that exceeds 15% of the project's value results in a disproportionate impact to projects in high cost areas, particularly for preservation efforts that involve moderate rehabilitation; and the proposed change makes the program standard comparable to other similar FHA multifamily insurance programs that are required to impose prevailing wage requirements.

Additionally, this proposed rule would revise §§ 266.600, 266.602, and 266.604, which currently refer to specific prescribed percentages for calculating an HFA's mortgage insurance premium (MIP). These set percentages are no longer appropriate now that the Section 542(c) HFA Risk-Sharing program is no longer a pilot. This proposed rule would revise the regulations to permit MIP changes for the HFA Risk-Sharing program to be published through **Federal Register** notice, with an opportunity for public comment, as is the case for other FHA programs.

F. Editorial Changes

Finally, this proposed rule makes a number of minor editorial changes to improve readability and clarity, and to ensure consistency and accuracy within the rule. For example, this proposed rule, throughout, adds and updates reference citations, standardizes the case of the term ''contract of insurance,'' replaces the term ''HUD Field Office'' with ''local HUD office,'' deletes the term ''his or her'' where it is unnecessary, specifies that references to days are measured in calendar days, and replaces a reference to the ''Office of General Counsel'' with simply ''HUD.'' HUD also has revised § 266.225(a)(1)(i) to clarify HUD's intent that Davis-Bacon wage requirements apply only where advances that are for construction of the project are insured under Part 266. This intent is reflected in § 266.225(d)(2) of the current regulation, which requires that no advance for a project subject to Davis-Bacon requirements shall be insured unless a certificate is filed with the application for the advance certifying that the laborers and mechanics employed in the construction of the project have been paid the Davis-Bacon prevailing wages. HUD has also revised § 266.225(c) to clarify that HUD has responsibility for enforcing Davis-Bacon labor standards under this section, and has revised § 266.630(d)(2) to clarify that partial claim payments are limited to the amount specified. HUD has made similar editorial changes of this nature.

III. Justification for Reduced Comment Period

For proposed rules issued for public comment, it is HUD's policy to afford the public ''not less than sixty days for submission of comments'' (24 CFR 10.1). In cases in which HUD determines that a shorter public comment period may be appropriate, it is also HUD's policy to provide an explanation of why the public comment period has been abbreviated. For the following reasons, HUD believes that a reduced 30-day comment period is justified for this proposed rulemaking.

This proposed rule updates regulations for the Section 542(c) HFA Risk-Sharing program to reflect statutory changes and to revise outdated references. These regulatory changes are technical and non-substantive. The proposed rule also better aligns HUD's regulations with current industry and current HUD practices and policies, and provides greater flexibility to HUD in operating the program and to certain

HFA's. In general, these amendments alleviate the administrative burdens imposed on program participants.

Further, these policy changes have already been discussed with, and are supported by stakeholders. From 2011–2013, HUD discussed proposed changes to the Risk-Sharing program with the National Council of State Housing Agencies (NCSHA) and a working group of HFAs. In October, 2014, HUD circulated a summary matrix of proposed changes to the program to NCSHA and HFAs and requested input on the proposals. Comments from NCSHA and HFAs have been overwhelmingly supportive of almost all of the revisions in the proposed rule.

Although HUD believes that an abbreviated comment period is appropriate, HUD welcomes public input and is soliciting comments for a period of 30-days. All comments will be considered in the development of the final rule.

IV. Findings and Certifications

Regulatory Review—Executive Orders 12866 and 13563

Under Executive Order 12866 (Regulatory Planning and Review), a determination must be made whether a regulatory action is significant and therefore, subject to review by the Office of Management and Budget (OMB) in accordance with the requirements of the order. Executive Order 13563 (Improving Regulations and Regulatory Review) directs executive agencies to analyze regulations that are ''outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them in accordance with what has been learned.''

This proposed rule updates HUD's regulations pertaining to Housing Finance Agency Risk Sharing Program for Insured Affordable Multifamily Project Loans, codified in 24 CFR part 266. The program regulations were initially promulgated in 1994, with the last updates undertaken in 2000, but only to a few regulatory sections. This update is undertaken to reflect statutory changes and revise outdated references and terminology. The proposed rule also better aligns HUD's regulations with current industry and current HUD practices and policies. These changes would not create additional significant burdens for the public. As a result, this rule was determined to not be a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and therefore was not reviewed by the Office of Management and Budget.

Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities.

The majority of the proposed regulatory amendments would update the regulations governing HUD's HFA Risk-Sharing program to conform to current industry practices and FHA policies with which HFAs and other program participants are already familiar. Other proposed regulatory changes will provide greater flexibility for HFAs, alleviating administrative burden and related costs of operating the program. While there may be some costs for HFAs to update their practices and procedures to reflect some of the regulatory changes, these costs are minimal in comparison to the streamlining benefits provided by the revised program regulations.

For the reasons presented, the undersigned certifies that this rule will not have a significant economic impact on a substantial number of small entities.

Executive Order 13132, Federalism

Executive Order 13132 (entitled ''Federalism'') prohibits an agency from publishing any rule that has Federalism implications if the rule either imposes substantial direct compliance costs on state and local governments and is not required by statute, or the rule preempts state law, unless the agency meets the consultation and funding requirements of section 6 of the Executive order. This proposed rule would not have Federalism implications and would not impose substantial direct compliance costs on state and local governments or preempt state law within the meaning of the Executive order.

Environmental Impact

A Finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations at 24 CFR part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)(C)). The Finding of No Significant Impact is available for public inspection during regular business hours in the Regulations Division, Office of General Counsel, Department of Housing and Urban Development, 451 Seventh Street SW., Room 10276, Washington, DC 20410–0500. Due to security measures at the HUD Headquarters building, please schedule an appointment to review the Finding by calling the Regulations Division at (202) 402–3055 (this is not a toll-free number). Individuals with speech or hearing impairments may access this number via TTY by calling the Federal Relay Service at (800) 877–8339.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4; approved March 22, 1995) (UMRA) establishes requirements for Federal agencies to assess the effects of their regulatory actions on state, local, and tribal governments, and on the private sector. This proposed rule does not impose any Federal mandates on any state, local, or tribal government, or on the private sector, within the meaning of the UMRA.

Information Collection Requirements

The information collection requirements contained in this proposed rule have been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520) and assigned OMB control number 2502–0500. In accordance with the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance (CFDA) Program number for the Housing Finance Agencies Section 542(c) Risk Sharing Program is 14.188.

List of Subjects in 24 CFR Part 266

Intergovernmental relations, Low and moderate income housing, Mortgage insurance, Reporting and recordkeeping requirements.

Accordingly, for the reasons stated above, HUD proposes to amend 24 CFR part 266 as follows:

PART 266—HOUSING FINANCE AGENCY RISK-SHARING PROGRAM FOR INSURED AFFORDABLE MULTIFAMILY PROJECT LOANS

■ 1. The authority citation for 24 CFR part 266 is revised to read as follows:

Authority: 12 U.S.C. 1715z–22.; 42 U.S.C. 3535(d).

■ 2. Amend part 266 by removing the words ''Contract of Insurance'' and add in their place the words ''contract of insurance'' wherever they occur.

■ 3. Revise § 266.1 to read as follows:

§ 266.1 Purpose and scope.

(a) *Authority and scope.* (1) Section 542 of the Housing and Community Development Act of 1992 (12 U.S.C. 1715z–22), directs the Secretary of the Department of Housing and Urban Development (HUD), acting through the Federal Housing Administration (FHA), to carry out programs that will provide new forms of Federal credit enhancement for multifamily loans. Section 542, entitled, ''Multifamily Mortgage Credit Programs,'' provides insurance authority independent from that provided by the National Housing Act.

(2) Section 542(c) of the Housing and Community Development Act of 1992 specifically directs HUD to carry out a program of risk-sharing with qualified State and local housing finance agencies (HFAs). The qualified HFAs are authorized to underwrite and process loans. HUD provides full mortgage insurance on affordable multifamily housing projects processed by such HFAs under this program. Through risk-sharing agreements with HUD, HFAs contract to reimburse HUD for a portion of the loss from any defaults that occur while HUD insurance is in force.

(3) The extent to which HUD directs qualified HFAs regarding their underwriting standards, loan terms and conditions, and asset management and servicing procedures is related to the proportion of the risk taken by an HFA.

(b) *Purpose.* The primary purpose of this program is to provide credit enhancement for multifamily loans, *i.e.,* utilization of full insurance by HUD, pursuant to risk-sharing agreements with qualified housing finance agencies, for the development of affordable housing. The utilization of Federal credit enhancements increases access to capital markets and, thereby, increases the supply of affordable multifamily housing. By permitting HFAs to underwrite, process, and service loans and to manage and dispose of properties that fall into default, affordable housing is made available to eligible families and individuals in a timely manner.

■ 4. Amend § 266.5 as follows:

■ a. Remove '', as amended'' from the definition of ''Act'';

■ b. Revise the definition of ''Affordable housing'';

■ c. Remove from the definition of ''Commissioner'' the words ''his or her'' and add in their place the words ''the Commissioner's'';

■ d. Revise the definition of ''Credit subsidy'';

■ e. Remove from the definition of ''Designated offices'' the words ''HUD Field Offices'' and add in their place the words ''local HUD offices'';

■ f. Remove the definition of ''Gross rent'';

■ g. Remove from the definition of ''Multifamily housing'' the word ''Secretary'' and add in its place the word ''Commissioner''; and

■ h. Remove the definition of ''Supportive services''.

The revisions read as follows:

§ 266.5 Definitions.

* * * * *

Affordable housing means a project that meets the requirements for a qualified low-income housing project under section 42(g) of the Internal Revenue Code of 1986 (26 U.S.C. 42(g)). For purposes of this part, the reference to a utility allowance in 26 U.S.C. 42(g) includes charges for the occupancy of a cooperative unit.

* * * * *

Credit subsidy means the cost of a direct loan or loan guarantee under the Federal Credit Reform Act of 1990 (subtitle B of title XIII of the Omnibus Budget Reconciliation Act of 1990, Public Law 101–508, approved Nov. 5, 1990).

* * * * *

§ 266.10 [Removed]

■ 5. Remove § 266.10.

■ 6. Revise § 266.30 to read as follows:

§ 266.30 Nonapplicability of 24 CFR part 246.

The regulations at 24 CFR part 246, pertaining to local rent control, do not apply to projects that are security for mortgages insured under this part.

■ 7. In § 266.100:

■ a. Revise the first sentence of paragraph (a);

■ b. Revise paragraphs (a)(1), (a)(6)(i), and(b)(1);

■ c. Revise the introductory text of paragraph (b)(2);

■ d. Revise paragraph (b)(3); and

■ e. Add paragraph (b)(4).

The revisions and additions read as follows:

§ 266.100 Qualified housing finance agency (HFA).

(a) *Qualifications.* To participate in the program, an HFA must apply and be specifically approved for the program described in this part, in addition to being approved as a mortgagee under § 202.10 of this part. * * *

(1) Carry an issuer credit rating of ''A'' or better, or an equivalent as evaluated by Standard and Poor's or any other nationally recognized rating agency; or

* * * * *

(6) * * *

(i) The Department of Justice has not brought a civil rights suit against the HFA, and no suit is pending;

* * * * *

(b) * * *

(1) Level I approval to originate, service, and dispose of multifamily mortgages where the HFA uses its own underwriting standards, loan terms and conditions, and asset management and servicing procedures, and assumes 50 to 90 percent of the risk of loss (in 10 percent increments).

(2) Level II approval to originate, service, and dispose of multifamily mortgages where the HFA uses underwriting standards, loan terms and conditions, and asset management and servicing procedures approved by HUD, and:

* * * * *

(3) For HFAs who plan to use Level I and Level II processing, the underwriting standards, loan terms and conditions, and asset management and servicing procedures to be used on Level II loans must be approved by HUD.

(4) Every five years, HUD will review the underwriting standards, loan terms and conditions, and asset management and servicing procedures for HFAs with Level II approval. HUD may require changes to these procedures as a condition for continued Level II approval.

■ 8. Revise § 266.105(b) to read as follows:

§ 266.105 Application requirements.

* * * * *

(b) *Applications for participation in program.* Applications from HFAs for approval to participate in the program under this part may be submitted at any time, and must be submitted in the form and manner established by HUD.

■ 9. In § 266.110, revise the paragraph heading and the first sentence of paragraph (a) and the third sentence of paragraph (b)(1) to read as follows:

§ 266.110 Reserve requirements.

(a) *HFAs with an issuer credit rating of ''A'' or better or overall rating of ''A'' on general obligation bonds.* An HFA with an issuer credit rating of ''A'' or better, or an equivalent designation, or an HFA with an overall rating of ''A'' on its general obligation bonds, is not required to have additional reserves so long as the HFA maintains that designation or rating, unless the Commissioner determines that a prescribed level of reserves is necessary. * * *

* * * * *

(b) * * *

(1) * * * The account must be established prior to the execution of any risk-sharing agreement under this part in an initial amount of not less than $500,000. * * *

* * * * *

§ 266.115 [Amended]

■ 10. Amend § 266.115 to remove the words ''his or her'' from the first sentence in paragraph (a) and from paragraph (c).

■ 11. In § 266.120, revise paragraphs (d) and (e)(5) to read as follows:

§ 266.120 Actions for which sanctions may be imposed.

* * * * *

(d) Actions or conduct for which sanctions may be imposed against the HFA by HUD's Mortgagee Review Board under 24 CFR 25.9, which pertains to ''notice of administrative action''.

(e) * * *

(5) Maintain an issuer credit rating of ''A'' or better, or an equivalent designation, or overall rating of ''A'' on general obligation bonds (or if such rating is lost, comply with paragraph (e)(6) of this section);

* * * * *

■ 12. In § 266.125, revise paragraph (a)(6), add paragraph (a)(8), and revise the first sentence of paragraph (d)(1) to read as follows:

§ 266.125 Scope and nature of sanctions.

(a) * * *

(6) Recommend to the Commissioner that the HFA's mortgagee approval be withdrawn pursuant to 24 CFR part 25 (regulations of the Mortgagee Review Board) and/or that penalties be imposed pursuant to 24 CFR part 30 (regulations pertaining to Civil Money Penalties; Certain Prohibited Contact);

* * * * *

(8) Require the HFA to revise any or all of its underwriting, processing, asset management, or servicing policies and procedures as directed by the Commissioner.

* * * * *

(d) * * *

(1) Any sanction imposed by a designated office in writing will be immediately effective, will state the grounds for the action, and provide for the HFA's right to an informal hearing before the designated office representative or designee in the designated office. * * *

* * * * *

■ 13. In § 266.200:

■ a. Revise paragraphs (b)(2), (c), (d), (e), and (g);

■ b. Redesignate paragraph (h) as paragraph (i); and

■ c. Add new paragraph (h).

The revisions and additions read as follows:

§ 266.200 Eligible projects.

* * * * *

(b) * * *

(2) *Substantial rehabilitation* occurs when the scope of work to improve an existing project exceeds in aggregate cost a sum equal to the base per dwelling unit limit times the applicable high cost factor established by the Commissioner, or when the scope of work involves the replacement of two or more building systems. *Replacement* is when the cost of replacement work exceeds 50% of the cost of replacing the entire system. The base per dwelling unit limit is $15,000 for 2015, and will be adjusted annually based on the percentage change in the consumer price index.

(c) *Existing projects.* Financing of existing properties for acquisition or refinancing without substantial rehabilitation is allowed.

(1) If the financing will result in the preservation of affordable housing, where the property will be maintained as affordable housing for a period of at least 20 years, regardless of whether the loan is prepaid; and

(2) Project occupancy is not less than 93 percent (to include consideration of rent in arrears), based on the average occupancy in the project over the most recent 12 months; and

(3) The loan to be refinanced has not been in default within the 12 months prior to the date of the application for refinancing; and

(4) If applicable, the owner of the property agrees to renew the Housing Assistance Payments (HAP) contract for a 20-year term; and

(5) Existing and post-refinance HAP residual receipts are set aside to be used to reduce future HAP payments; and

(6) A capital needs assessment must be performed and funds escrowed for all necessary repairs and replacement reserves funded for future capital repairs; and

(7) The HUD-insured mortgage does not exceed an amount supportable by the lower of the unit rents being collected under the rental assistance agreement or the unit rents being collected at unassisted projects in the market area that are similar in amenities and location to the project for which insurance is being requested, although this paragraph does not apply to Level I participants if those projects are financed under section 202 of the Housing Act of 1959 (12 U.S.C. 1701q); and

(8) For Level II participants only, the HUD-insured mortgage may not exceed the sum of the existing indebtedness, cost of refinancing, or acquisition, the cost of repairs and reasonable transaction costs as determined by the Commissioner. This paragraph does not apply to Level I participants.

(d) *Projects receiving section 8 rental subsidies or other rental subsidies.* Projects receiving project-based housing assistance payments under section 8 of the U.S. Housing Act of 1937 (42 U.S.C. 1437f) or other rental subsidies and meeting the requirements of this part may be insured under this part only if the mortgage does not exceed an amount supportable by the lower of the unit rents being or to be collected under the rental assistance agreement or the unit rents being collected at unassisted projects in the market that are similar in amenities and location to the project for which insurance is being requested. This paragraph does not apply to projects of Level I participants if those projects are financed under section 202 of the Housing Act of 1959 (12 U.S.C. 1701q).

(e) *SRO projects.* Single room occupancy (SRO) projects, as defined in § 266.5, are eligible for insurance under this part. Units in SRO projects must be subject to 30-calendar day or longer leases; however, rent payments may be made on a weekly basis in SRO projects.

* * * * *

(g) *Elderly projects.* Projects or parts of projects specifically designed for the use and occupancy by elderly families. An elderly family means any household where the head or spouse is 62 years of age or older, including children under 18, and also any single person who is 62 years of age or older.

(h) *Housing for older persons.* Projects eligible for and in compliance with 42 U.S.C. 3607(b) and 24 CFR part 100, subpart E.

* * * * *

§ 266.205 [Amended]

■ 14. Amend § 266.205 by adding the word ''calendar'' after the number ''30'' in paragraph (a)(1) and adding the letters ''U.S.'' before the term ''Department of Defense'' in paragraph (b)(2).

■ 15. In § 266.210:

■ a. Remove paragraph (b);

■ b. Redesignate paragraphs (c), (d) and (e) as paragraphs (b), (c) and (d), respectively; and

■ c. Revise newly redesignated paragraphs (c) and (d) to read as follows:

§ 266.210 HUD-retained review functions.

* * * * *

(c) *Subsidy layering.* The Commissioner, or Housing Credit Agencies as defined by section 42 of the Internal Revenue Code of 1986 (26 U.S.C. 42), through such delegation as may be in effect by regulation hereafter, shall review all projects receiving tax credits and some form of HUD assistance for any excess subsidy provided to individual projects and reduce subsidy sources in accordance with outstanding guidelines.

(d) *Davis-Bacon Act.* The Commissioner shall obtain and provide to the HFA the appropriate U.S. Department of Labor wage rate determinations under the Davis-Bacon Act, where they apply under this part.

■ 16. Revise § 266.215(e) to read as follows:

§ 266.215 Functions delegated by HUD to HFAs.

* * * * *

(e) *Lead-based paint.* The HFA will perform functions related to Lead-based paint requirements as set forth in 24 CFR part 35, subparts A, B, G, and R.

■ 17. Add § 266.217 to read as follows:

§ 266.217 Environmental review requirements.

The responsible entity, as defined in 24 CFR part 58 (Environmental Review Procedures for Entities Assuming HUD Environmental Responsibilities), assumes legal responsibility for compliance with the requirements of the National Environmental Policy Act of 1969 and related laws and authorities. The responsible entity will visit each project site proposed for insurance under this part and prepare the applicable environmental reviews as set forth in 24 CFR part 58. HUD may make a finding in accordance with 24 CFR 58.11 and may perform the environmental review itself under 24 CFR part 50 (Protection and Enhancement of Environmental Quality). In all cases the environmental review must be completed before HUD may issue the firm approval letter.

■ 18. Revise § 266.220 to read as follows:

§ 266.220 Nondiscrimination in housing and employment.

The mortgagor must certify to the HFA that, so long as the mortgage is insured under this part, the mortgagor will:

(a) Not use tenant selection procedures that discriminate against families with children, except in the case of a project qualifying for and complying with the requirements of the ''housing for older persons'' exemption, as defined in section 807(b)(2) of the Fair Housing Act (42 U.S.C. 3607(b)) and further described in 24 CFR part 100, subpart E. Projects receiving Federal financial assistance in which elderly families include minor children may not avail themselves of the housing for older persons exemption;

(b) Determine eligibility for admission and continued occupancy without regard to actual or perceived sexual orientation, gender identity, or marital status and refrain from inquiries about sexual orientation and gender identity in accordance with 24 CFR 5.105(a)(2);

(c)(1) Comply with:

(i) The Fair Housing Act (42 U.S.C. 3601 through 3619), as implemented by 24 CFR part 100;

(ii) Titles II and III of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 through 12213), as implemented by 28 CFR part 35;

(iii) Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u), as implemented by 24 CFR part 135;

(iv) The Equal Credit Opportunity Act (15 U.S C. 1691–1691f), as implemented by 12 CFR part 202;

(v) Executive Order 11063, as amended by Executive Order 12259 (3 CFR 1958–1963 Comp., p. 652 and 3 CFR 1980 Comp., p. 307), and implemented by 24 CFR part 107;

(vi) Executive Order 11246 (3 CFR 1964–1965 Comp., p. 339), as implemented by 41 CFR part 60; and

(vii) Other applicable Federal laws and regulations issued pursuant to these authorities; and applicable State and local fair housing and equal opportunity laws.

(2) In addition to the authorities listed in paragraph (c)(1) of this section, a mortgagor that receives Federal financial assistance must also certify to the HFA that, so long as the mortgage is insured under this part, it will comply with:

(i) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), as implemented by 24 CFR part 1;

(ii) The Age Discrimination Act of 1975 (42 U.S.C. 6101 through 6107), as implemented by 24 CFR part 146; and

(iii) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), as implemented by 24 CFR part 8.

■ 19. In § 266.225, revise the introductory text of paragraph (a)(1), and revise paragraphs (a)(1)(i), (b), (c), (d)(1), and the second sentence of paragraph (e) to read as follows:

§ 266.225 Labor standards.

(a) * * *

(1) All laborers and mechanics employed by contractors or subcontractors on a project insured under this part shall be paid not less than the wages prevailing in the locality in which the work was performed for the corresponding classes of laborers and mechanics employed in construction of a similar character, as determined by the Secretary of the U.S. Department of Labor (Secretary of Labor) in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 3141 *et seq.*), where the project meets all of the following conditions:

(i) Advances for construction of the project are insured under this part;

* * * * *

(b) *Volunteers.* The provisions of this section shall not apply to volunteers under the conditions set out in 24 CFR part 70 (Use of Volunteers on Projects Subject to Davis-Bacon and HUD-Determined Wage Rates). In applying 24 CFR part 70, insurance under this part shall be treated as a program for which there is a statutory exemption for volunteers.

(c) *Labor standards.* Any contract, subcontract, or building loan agreement executed for a project subject to Davis-Bacon wage rates under paragraph (a) of this section shall comply with all labor standards and provisions of the U.S. Department of Labor regulations in 29 CFR parts 1, 3, and 5 that would be applicable to a mortgage insurance program to which Davis-Bacon wage rates are made applicable by statute, provided, that regulatory provisions relating to investigations and enforcement by the U.S. Department of Labor shall not be applicable, and enforcement of Davis-Bacon labor standards shall be the responsibility of the Commissioner in accordance with paragraph (e) of this section.

(d) * * *

(1) No advance under a mortgage on a project subject to Davis-Bacon wage rates under paragraph (a) of this section shall be eligible for insurance under this part unless the HFA determines (in accordance with the Commissioner's administrative procedures) that the general contractor or any subcontractor or any firm, corporation, partnership or association in which the contractor or subcontractor has a substantial interest was not, on the date the contract or subcontract was executed, on the ineligible list established by the Comptroller General of the United States, pursuant to 29 CFR 5.12, issued by the Secretary of Labor.

* * * * *

(e) * * * Where routine administration and enforcement functions are delegated to the HFA, the HFA shall bear financial responsibility for any deficiency in payment of prevailing wages or, where applicable

under 29 CFR part 1 (Procedures for Predetermination of Wage Rates), any increase in compensation to a contractor, that is attributable to any failure properly to carry out its delegated functions. * * *

■ 20. In § 266.300:

■ a. Revise paragraph (b)(1);

■ b. Redesignate existing paragraphs (b)(3), (b)(4), and (b)(5) as paragraphs (b)(4), (b)(5), and (b)(6), respectively;

■ c. Add new paragraph (b)(3);

■ d. Revise newly redesignated paragraph (b)(5); and

■ e. Revise paragraph (c).

The revisions and additions read as follows:

§ 266.300 HFAs accepting 50 percent or more of risk.

* * * * *

(b) * * *

(1) Determine that a market for the project exists, taking into consideration any comments from the local HUD office relative to the potential adverse impact the project will have on existing or proposed Federally insured and assisted projects in the area.

* * * * *

(3) Arrange for the performance of an environmental review in accordance with § 266.217;

* * * * *

(5) Approve the Affirmative Fair Housing Marketing Plan, required by § 266.215(a); and

* * * * *

(c) *HUD-retained reviews.* After positive completion of the HUD-retained reviews specified in § 266.210(a) and (b) the local HUD office will issue a firm approval letter.

* * * * *

■ 21. In § 266.305:

■ a. Revise paragraphs (a) and (b)(1);

■ b. Redesignate existing paragraphs (b)(3), (b)(4), and (b)(5) as paragraphs (b)(4), (b)(5), and (b)(6), respectively;

■ c. Add new paragraph (b)(3);

■ d. Revise newly redesignated paragraph (b)(5), and

■ e. Revise paragraph (c).

The revisions and additions read as follows:

§ 266.305 HFAs accepting less than 50 percent of risk.

(a) *Underwriting standards.* The underwriting standards and loan terms and conditions of any HFA electing to take less than 50 percent of the risk on certain projects are subject to review, modification, and approval by HUD in accordance with § 266.100(b). These HFAs may assume 25 percent or 10 percent of the risk depending upon the loan-to-replacement-cost or loan-to-value ratios of the projects to be insured as specified in § 266.100(b)(2)(i) and (ii). Large loans, as defined by HUD for its insured multifamily mortgage programs, require prior approval by the Commissioner.

(b) * * *

(1) Determine that a market for the project exists, taking into consideration any comments from the local HUD office relative to the potential adverse impact the project will have on existing or proposed Federally insured and assisted projects in the area;

* * * * *

(3) Arrange for the performance of an environmental review in accordance with § 266.217;

* * * * *

(5) Approve the Affirmative Fair Housing Marketing Plan, required by § 266.215(a); and

* * * * *

(c) *HUD-retained reviews.* After positive completion of the HUD-retained reviews specified in § 266.210(a) and (b), the local HUD office will issue a firm approval letter.

* * * * *

■ 22. In § 266.410, revise paragraph (e) to read as follows:

§ 266.410 Mortgage provisions.

* * * * *

(e) *Amortization.* The mortgage must provide for complete amortization (*i.e.,* be regularly amortizing) over the term of the mortgage. The complete amortization requirement does not apply to:

(1) Construction loans, or

(2) Level I participants where the loan has a minimum term of 17 years and the HFA's underwriting standards, loan terms and conditions, and asset management and servicing procedures have been approved by HUD.

* * * * *

■ 23. In § 266.420, revise the second sentence of paragraph (a) and paragraphs (b)(3), (4), and (7), and add paragraph (b)(13) to read as follows:

§ 266.420 Closing and endorsement by the Commissioner.

(a) * * * The note must provide that the mortgage is insured under section 542(c) of the Housing and Community Development Act of 1992 and the regulations set forth in this part that are in effect on the date of endorsement. * * *

* * * * *

(b) * * *

(3) Certification that the loan has been processed, prudently underwritten (including a determination that a market exists for the project), cost certified (if the project is being submitted for final endorsement) and closed in full compliance with the HFA's standards and requirements (or where the mortgage is insured under Level II, in full compliance with the underwriting standards, loan terms and conditions, and asset management and servicing procedures, as approved by HUD).

(4) At the time of final endorsement, for periodic advances cases, a certification that the advances were made in accordance with the mortgage pursuant to § 266.310.

* * * * *

(7) A certification that the HFA has reviewed and approved the Affirmative Fair Housing Marketing Plan, required by § 266.215(a), and found it acceptable.

* * * * *

(13) Certification that housing claiming the housing for older persons exemption is eligible for and complies with 42 U.S.C. 3607(b) and 24 CFR part 100, subpart E.

■ 24. Revise § 266.500 to read as follows:

§ 266.500 General.

(a) *HFA responsibility for monitoring project owners.* The HFA will have full responsibility for managing and servicing projects insured under this part (in accordance with procedures disclosed and submitted with its application and the requirements of this part). The HFA is responsible for monitoring and determining the compliance of the project owner in accordance with the provisions of this subpart. HUD will monitor the performance of the HFA, not the project owner, to determine its compliance with the provisions covered under this subpart.

(b) *HUD review of procedures for HFAs with Level II approval.* Asset management and servicing procedures of any HFA electing to take less than 50 percent of the risk on certain projects are subject to review, modification, and approval by HUD in accordance with § 266.100(b).

§ 266.505 [Amended]

■ 25. Amend § 266.505:

■ a. In paragraph (b)(8), after the word ''Plan'' by adding the phrase '', required by § 266.215(a),'';

■ b. In paragraph (b)(10), by removing the words ''General Accounting'' and adding in their place ''U.S. Government Accountability''.

■ 26. Revise § 266.507 to read as follows:

§ 266.507 Maintenance requirements.

The mortgagor must maintain the project in accordance with the physical

condition standards in 24 CFR part 5, subpart G (Physical Condition Standards and Inspection Requirements).

■ 27. Revise § 266.510(a) to read as follows:

§ 266.510 HFA responsibilities.

(a) *Inspections.* The HFA must perform inspections in accordance with the physical inspection procedures in 24 CFR part 5, subpart G (Physical Condition Standards and Inspection Requirements).

* * * * *

■ 28. Revise § 266.600 to read as follows:

§ 266.600 Mortgage insurance premium: insurance upon completion.

(a) *Initial premium.* For projects insured upon completion, on the date of the final closing, the HFA shall pay to the Commissioner an initial premium in an amount established by the Commissioner under § 266.604.

(b) *Premium payable with first payment of principal.* On the date of the first payment of principal the HFA shall pay a second premium (calculated on a per annum basis) in an amount established by the Commissioner under § 266.604.

(c) *Subsequent premiums.* Until one of the conditions is met under § 266.606(a), the HFA on each anniversary of the date of the first principal payment shall pay to the Commissioner an annual mortgage insurance premium in an amount established by the Commissioner under § 266.604, without taking into account delinquent payments, or partial claim payment under § 266.630, or prepayments, for the year following the date on which the premium becomes payable.

■ 29. In § 266.602, revise paragraph (a), the first sentence of paragraph (b), the first sentence of paragraph (c), and paragraph (d) to read as follows:

§ 266.602 Mortgage insurance premium: Insured advances.

(a) *Initial premium.* For projects involving insured advances, on the date of the initial closing, the HFA shall pay to the Commissioner an initial premium equal to an amount established by the Commissioner under § 266.604.

(b) *Interim premium.* On each anniversary of the initial closing, the HFA shall pay an interim mortgage insurance premium in an amount established by the Commissioner under § 266.604. * * *

(c) *Premium payable with first payment of principal.* On the date of the first principal payment, the HFA shall pay a mortgage insurance premium in an amount established by the Commissioner under § 266.604. * * *

(d) *Subsequent premiums.* Until one of the conditions is met under § 266.606(a), the HFA on each anniversary of the date of the first principal payment shall pay to the Commissioner an annual mortgage insurance premium in an amount established by the Commissioner under § 266.604, without taking into account delinquent payments, prepayments, or a partial claim payment under § 266.630, for the year following the date on which the premium becomes payable.

■ 30. In § 266.604, revise paragraphs (a) and (b), the first sentence of paragraph (c), and the second and third sentences of paragraph (d) to read as follows:

§ 266.604 Mortgage insurance premium: Other requirements.

(a) *Premium calculations on or after first principal payment.* The premiums payable to the Commissioner on and after the first principal payment shall be calculated in accordance with the amortization schedule prepared by the HFA for final closing and an amount established by the Commissioner through a notice published in the **Federal Register** and providing a 30-day comment period. After the comments have been considered, HUD will publish a final notice announcing the premium and its effective date. The premium shall not take into account delinquent payments or prepayments.

(b) *Future premium changes.* Notice of future premium changes will be published in the **Federal Register**. The Commissioner will propose mortgage insurance premium changes for the Risk-Sharing Program and provide a 30-calendar day public comment period for the purpose of accepting comments on whether the proposed changes are appropriate. After the comments have been considered, HUD will publish a final notice announcing the premium and its effective date.

(c) *Closing information.* The HFA shall provide final closing information to the Commissioner within 15 calendar days of the final closing in a format prescribed by the Commissioner. * * *

(d) *Due date for premium payments.* * * * Any premium received by the Commissioner more than 15 calendar days after the due date shall be assessed a late charge of 4 percent of the amount of the premium payment due. Mortgage insurance premiums that are paid to the Commissioner more than 30 calendar days after the due date shall begin to accrue interest at the rate prescribed by the Treasury Fiscal Requirements Manual.

■ 31. In § 266.620:

■ a. Revise the section heading;

■ b. Redesignate the undesignated introductory paragraph as paragraph (a) and redesignate existing paragraphs (a) through (g), as paragraphs (a)(1) through (7), respectively; and

■ c. Add a new paragraph (b).

The revision and addition read as follows:

§ 266.620 Termination of contract of insurance and indemnification.

* * * * *

(b) In lieu of termination of the mortgage insurance contract pursuant to paragraph (a)(5) of this section, the Commissioner may, in his or her full discretion, permit a Level I participant rated ''A'' or higher to indemnify HUD, or otherwise reimburse HUD in a manner acceptable to the Commissioner, for the full amount of the mortgage claim.

■ 32. In § 266.626, revise the first sentence of paragraph (c) and revise paragraph (d) to read as follows:

§ 266.626 Notice and date of termination by the Commissioner.

* * * * *

(c) *Notice of default.* If a default (as defined in paragraph (a) of this section) continues for a period of 30 calendar days, the HFA must notify the Commissioner within 10 calendar days thereafter, unless the default is cured within the 30-day period. * * *

(d) *Timing of claim filing.* Unless a written extension is granted by HUD, the HFA must file an application for initial claim payment (or, if appropriate, for partial claim payment) within 75 calendar days from the date of default and may do so as early as the first day of the month following the month for which a payment was missed. Upon request of the HFA, HUD may extend, up to 180 calendar days from the date of default, the deadline for filing a claim. In those cases where the HFA certifies that the project owner is in the process of transacting a bond refunder, refinancing the mortgage, or changing the ownership for the purpose of curing the default and bringing the mortgage current, HUD may extend the deadline for filing a claim beyond 180 calendar days, not to exceed 360 calendar days from the date of default.

■ 33. Revise § 266.628(a)(3) to read as follows:

§ 266.628 Initial claim payments.

(a) * * *

(3) The HFA must use the proceeds of the initial claim payment to retire any bonds or any other financing mechanisms securing the mortgage

within 30 calendar days of the initial claim payment. Any excess funds resulting from such retirement or repayment shall be returned to HUD within 30 calendar days of the retirement.

* * * * *

■ 34. In § 266.630, revise the second sentence of paragraph (c)(2), paragraphs (d)(1), (2), and (4), and the second sentence of paragraph (d)(5) to read as follows:

§ 266.630 Partial payment of claims.

* * * * *

(c) * * *

(2) * * * The HFA is granted an extension of 30 calendar days from the date of any notification for further action.

(d) *Requirements*—(1) *One partial claim payment.* Only one partial claim payment may be made under a contract of insurance.

(2) *Partial claim payment amount.* The amount of the partial claim payment is limited to 50% of the amount of relief provided by the HFA in the form of a reduction in principal and a reduction of delinquent interest due on the insured mortgage times the lesser of HUD's percentage of the risk of loss or 50 percent.

* * * * *

(4) *Partial claim repayment by HFA.* The HFA must remit to HUD a percentage of all amounts collected on the HFA's second mortgage within 15 calendar days of receipt by the HFA. The applicable percentage is equal to the percentage used in paragraph (d)(2) of this section to determine the partial claim payment amount. Payments made after the 15th day must include a 5 percent late charge plus accrued interest at the Debenture rate.

(5) * * * The HFA must submit a final certified statement within 30 calendar days after the second mortgage is paid in full, foreclosed, or otherwise terminated.

§ 266.634 [Amended]

■ 35. Amend § 266.634(c) by adding the word ''calendar'' immediately before the word ''days'' in the first sentence.

§ 266.638 [Amended]

■ 36. Amend § 266.638 to:

■ a. Add the word ''calendar'' immediately before the word ''days'' in the first sentence of paragraph (a);

■ b. Remove the word ''five'' from the second sentence of paragraph (b), and add in its place the number ''5'';

■ c. Remove the words ''five year'' from the third sentence of paragraph (b) and add in their place ''5-year''.

§ 266.642 [Amended]

■ 37. Amend the third sentence of § 266.642 to remove the phrase ''45-day'' and in its place add the phrase ''45-calendar day''.

§ 266.644 [Amended]

■ 38. Amend § 266.644 to add the word ''calendar'' before the word ''days'' in the undesignated introductory paragraph

§ 266.648 [Amended]

■ 39. Amend § 266.648(c)(4) to remove the words ''the Office of General Counsel'' and add in their place ''HUD''.

■ 40. In § 266.650, revise paragraph (a) to read as follows:

§ 266.650 Items deducted from total loss.

* * * * *

(a) All amounts received by the HFA on account of the mortgage after the date of default, including any partial payment of claim paid by HUD in the event a full claim follows a partial payment of claim;

* * * * *

§ 266.654 [Amended]

■ 41. Amend § 266.654(b) to add the word ''calendar'' before the word ''days'' in the first sentence.

Dated: February 25, 2016.

Edward Golding,

Principal Deputy Assistant Secretary for Housing.

[FR Doc. 2016–04595 Filed 3–7–16; 8:45 am]

BILLING CODE 4210–67–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[WC Docket No. 12–375; Report 3038]

Petition for Reconsideration of Action in a Rulemaking Proceeding

AGENCY: Federal Communications Commission.

ACTION: Petition for reconsideration.

SUMMARY: A Petition for Reconsideration (Petition) has been filed in the Commission's Rulemaking proceeding by Michael S. Hamden, on behalf of himself.

DATES: Oppositions to the Petition must be filed on or before March 23, 2016. Replies to an opposition must be filed on or before April 4, 2016.

ADDRESSES: Federal Communications Commission, 445 12th Street SW., Washington DC 20554.

FOR FURTHER INFORMATION CONTACT: Gil Strobel, Wireline Competition Bureau, 202–418–7084, *Gil.Strobel@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's document, Report No. 3038, released February 11, 2016. The full text of Report No. 3038 is available for viewing and copying in Room CY–B402, 445 12th Street SW., Washington, DC. The Commission will not send a copy of this document pursuant to the Congressional Review Act, 5 U.S.C. 801(a)(1)(A), because this document does not have an impact on any rules of particular applicability.

Subject: In the Matter of Rules for Interstate Inmate Calling Services, WC Docket No. 12–375, published at 80 FR 79136, December 18, 2015. This notice is published pursuant to § 1.429 of the Commission's rules, 47 CFR 1.429. *See also* 47 CFR 1.4(b)(1).

Number of Petitions Filed: 1.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 2016–05014 Filed 3–7–16; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 350, 365, 385, 386, 387, and 395

[Docket No. FMCSA–2015–0001]

RIN 2126–AB11

Carrier Safety Fitness Determination

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice; extension of comment period and technical correction.

SUMMARY: FMCSA extends the public comment period for the Agency's notice of proposed rulemaking (NPRM) that published on January 21, 2016. This NPRM concerns the proposals to the current methodology for issuance of safety fitness determinations (SFD) for motor carriers. The Agency extends the deadline for the submission of initial comments to May 23, 2016. Reply comments will be due on or before June 23, 2016. In addition, FMCSA corrects the title and date of an American Transportation Research Institute (ATRI) study report that the NPRM cited about the Agency's Safety Measurement System (SMS).

DATES: FMCSA is extending the initial comment period for the proposed rulemaking published on January 21, 2016 (81 FR 3562). You must submit comments by May 23, 2016, and reply comments on or before June 23, 2016.

ADDRESSES: You may submit comments (initial and reply) identified by the docket number FMCSA–2015–0001 using any of the following methods:

- *Web site: http://www.regulations.gov.* Follow the instructions for submitting comments on the Federal electronic docket site.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Services, U.S. Department of Transportation, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001.
- *Hand Delivery:* Ground Floor, Room W12–140, DOT Building, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m. Monday through Friday, except Federal holidays.

To avoid duplication, please use only one of these four methods. See the ''Public Participation and Request for Comments'' portion of the **SUPPLEMENTARY INFORMATION** section below for instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: Mr. David Yessen, (609) 275–2606, *David.Yessen@dot.gov.* FMCSA office hours are from 7:30 a.m. to 4 p.m., Monday through Friday, except Federal holidays. If you have questions on viewing or submitting material to the docket, call Docket Services, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

I. Public Participation and Request for Comments

FMCSA encourages you to participate in this rulemaking by submitting comments, reply comments, and related materials. All comments received will be posted without change to *http://www.regulations.gov* and will include any personal information you provide.

A. Submitting Comments

Initial comments may address any issue raised in the NPRM and the background documents in the docket (*e.g.,* Regulatory Evaluation, studies). Initial comments will be made available promptly online on *http://www.regulations.gov* and for public inspection in room W12–140, DOT Building, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. In order to allow sufficient opportunity for interested parties to prepare and submit any reply comments, late-filed initial comments will not be considered. Reply comments must address only matters raised in initial comments and must not be used to present new arguments, contentions, or factual material that is not responsive to the initial comments.

If you submit a comment or a reply comment, please include the docket number for this rulemaking (FMCSA–2015–0001), indicate the specific section of this document to which each comment or reply comment applies, and provide a reason for each suggestion or recommendation. You may submit your comments, reply comments and material online or by fax, mail, or hand delivery, but please use only one of these means. FMCSA recommends that you include your name and a mailing address, an email address, or a phone number in the body of your document so the Agency can contact you if it has questions regarding your submission.

To submit your comment or reply comment online, go to *http://www.regulations.gov* and insert ''FMCSA–2015–0001'' in the ''Search'' box, and then click the ''Search'' button to the right of the white box. Click on the top ''Comment Now'' box which appears next to the document. Fill in your contact information, as desired and your comment or reply comment, uploading documents if appropriate. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments or reply comments by mail and would like to know that they reached the facility, please enclose a stamped, self-addressed postcard or envelope.

FMCSA will consider all comments, reply comments and material received during the comment period and may change this proposed rule based on your comments.

B. Viewing Comments and Documents

To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov* and insert ''FMCSA–2015–0001'' in the ''Search'' box and then click on ''Search.'' Click on the ''Open Docket Folder'' link and all the information for the document, and the list of comments will appear with a link to each one. Click on the comment you would like to read. If you do not have access to the Internet, you may view the docket online by visiting the Docket Services in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

C. Privacy Act

In accordance with 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its rulemaking process. DOT posts these comments, without edit, including any personal information the commenter provides, to *www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *www.dot.gov/privacy.*

II. Background

On January 21, 2016 (81 FR 3562), FMCSA published an NPRM to amend the current methodology for issuance of SFDs for motor carriers. From February 3 to 5, 2016, the American Moving and Storage Association (AMSA), Transportation Intermediaries Association (TIA), and the Transportation & Logistics Council, Inc. (TL Council) petitioned the Agency for a 60-day extension of the comment period. On February 16, 2016, the Owner Operator Independent Drivers Association (OOIDA) petitioned the Agency for a 90-day extension of the comment period. A copy of the AMSA, TIA, TL Council, and OOIDA petitions are included in the docket referenced at the beginning of this document. After reviewing the requests, FMCSA has decided to grant a 60-day extension (to May 23, 2016, for initial comments and to June 23, 2016 for reply comments) to provide all interested parties adequate time to submit comments on proposals in this rulemaking.

In addition, Rebecca M. Brewster, President and Chief Operating Officer of the American Transportation Research Institute (ATRI), informed FMCSA that the NPRM incorrectly cited an ATRI study (81 FR 3562, at 3567, third column) on the Agency's Behavioral Analysis and Safety Improvement Categories (BASICs) and their relationship to crash risk. The study erroneously cited by FMCSA was a qualitative study of motor carrier, driver, law enforcement and shipper survey data. The ATRI study on the BASICs was released in October 2012 and is titled ''Compliance, Safety, Accountability: Analyzing the Relationship of Scores to Crash Risk.'' It involved an analysis of carriers assessed by BASICs. The results confirmed that FMCSA's Safety Measurement System (SMS) is better at targeting carriers and identifying safety problems than the current SafeStat, the Agency's previous intervention prioritization system. In addition, the ATRI study indicated that the number of ''alerts'' a carrier has is the best indicator of future crashes.

FMCSA has included the correct report in the docket for the public's consideration of the Carrier Safety Fitness Determination NPRM.

Issued on: March 1, 2016.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2016–05151 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–EX–P

Notices

Federal Register
Vol. 81, No. 45
Tuesday, March 8, 2016

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

Submission for OMB Review; Comment Request

March 2, 2016.

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments are requested regarding (1) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments regarding this information collection received by April 7, 2016 will be considered. Written comments should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), *OIRA_Submission@omb.eop.gov* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Copies of the submission(s) may be obtained by calling (202) 720–8958.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Food and Nutrition Service

Title: WIC Participant and Program Characteristics Study.

OMB Control Number: 0584–NEW.

Summary of Collection: This data collection effort for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Participant and Program Characteristics Study is authorized by 7 CFR 246.25(b)(3) (2011). This legislation requires State and local agencies to provide information required by the U.S. Department of Agriculture's (USDA) Food and Nutrition Service (FNS) for the creation of biennial reports on WIC participant and program characteristics (PC). This information includes, at a minimum, income and nutritional risk characteristics of participants, information on breastfeeding incidence and duration, and participation in the program by category (pregnant, breastfeeding, and postpartum women; infants; and children) within each priority level (as established in 7 CFR 246.7 (e)(4)) and by migrant farmworker households. The study affirms USDA's Food, Nutrition, and Consumer Services' fourth strategic goal for 2014–2018: to ensure all of America's children have access to safe, nutritious, and balanced meals.

Need and Use of the Information: The WIC PC Study will collect updated program characteristics data from each of the 90 WIC State agencies. FNS uses this data for general program monitoring as well as for managing the information needs of the program. The data is used to estimate budgets, submit civil rights reporting, identify needs for research, and review current and proposed WIC policies and procedures. FNS uses this data to produce the WIC PC reports which provide the most comprehensive and up-to-date statistics on WIC.

Description of Respondents: State, Local, or Tribal Government.

Number of Respondents: 90.

Frequency of Responses: Reporting: Biennially.

Total Burden Hours: 530.

Food and Nutrition Service

Title: WIC Infant and Toddler Feeding Practices Study–2 (ITFPS–2) Age 5 Extension.

OMB Control Number: 0584–0580.

Summary of Collection: The Healthy, Hunger-Free Kids Act of 2010 (Pub. L. 111–296, Sec. 305) mandates programs under its authorization, including WIC, to cooperate with the United States Department of Agriculture (USDA) program research and evaluation activities. The USDA's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) serves a highly-vulnerable population: low-income pregnant and post-partum women, infants, and children through their fifth birthday who are at nutritional risk. The program provides supplemental food packages, health referrals and nutrition education for participants. The Age 5 Extension will follow children through the entire period of their WIC eligibility, and provide the data to answer research questions relevant to WIC program and policy as well as the nutrition and wellbeing of children up to their 5th birthday.

Need and Use of the Information: The study is needed to provide the Food and Nutrition Service with information on the factors that influence feeding practices and the nutrition and health outcomes of children in the first three years of their lives. The Age 5 Extension study will expand the data collection to their fifth year of life.

Description of Respondents: Individuals or households; Businesses or other for-profit institutions; Not-for-profit institutions; and State, Local or Tribal Government.

Number of Respondents: 5,869.

Frequency of Responses: Reporting: On occasion; semi-annually.

Total Burden Hours: 11,619.

Ruth Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. 2016–05065 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–30–P

DEPARTMENT OF AGRICULTURE

Forest Service

Wallowa-Whitman National Forest; Oregon; Notice of Intent to Cancel Preparation of a Supplement to the 2012 Final Environmental Impact Statement for Snow Basin Vegetation Management Project

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to cancel preparation of a supplemental environmental impact statement.

SUMMARY: On August 6, 2014, the USDA Forest Service published a Notice of Intent in the **Federal Register** (Vol. 79, No. 151, page 45761) to prepare a Supplement to the Snow Basin Vegetation Management Project Final Environmental Impact Statement (EIS) to address the environmental impact of the project on elk and elk habitat. The USDA Forest Service no longer intends to prepare the Supplement and the project has been cancelled.

FOR FURTHER INFORMATION CONTACT: Dea Nelson, Environmental Coordinator, Wallowa-Whitman National Forest, 1550 Dewey, Suite A, Baker City, OR 97814; or, 541–523–1216; or, *dnelson09@fs.fed.us.*

Individuals who use telecommunication devices for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

Thomas Montoya,

Forest Supervisor.

[FR Doc. 2016–05090 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–11–P

DEPARTMENT OF AGRICULTURE

Forest Service

Umatilla National Forest, North Fork John Day Ranger District; Oregon; Ten Cent Community Wildfire Protection Project

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an environmental impact statement.

SUMMARY: The USDA, Forest Service will prepare an Environmental Impact Statement (EIS) to analyze impacts for fuels treatment in the Granite Creek Watershed of the North Fork John Day Ranger District of the Umatilla National Forest and the Whitman Ranger District of the Wallowa-Whitman National Forest.

Scoping for the EIS was open for 30 days in July 2015 and numerous comments were received from the public. These comments were used to form the issues for the EIS.

DATES: The draft environmental impact statement is expected to be available for public comment in May 2016 and the final environmental impact statement is expected to be completed in September 2016.

FOR FURTHER INFORMATION CONTACT: Andrew Stinchfield, North Fork John Day Ranger District, P.O. Box 158, Ukiah, OR 97880, (541) 427–3231.

Individuals who use telecommunication devices for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

SUPPLEMENTARY INFORMATION:

Purpose and Need for Action

The purpose and need of the Ten Cent Community Wildfire Protection Project is to provide a safer working environment for firefighters while improving probability of success in protecting life and property associated with the adjacent private lands in the event of a wildfire within or threatening the values at risk (VAR) in the Granite Zone as defined by the Grant County Community Wildfire Protection Plan. These values at risk include the cities of Granite and Greenhorn, scattered inholdings (intermix), and the ingress/egress routes from private lands. Modeled flame lengths across the planning area are currently around 4.6 feet, with some stands showing modeled flame lengths as high as 20 feet. Many of the stands within the analysis area are predicted to exhibit active crown fires as well.

The desired condition would result in areas within the strategically placed Defensible Fuel Profile Zones (DFPZs) exhibiting flame lengths of less than 4 feet and reducing the probability of a wildfire burning through the crowns of live trees. Defensible Fuel Profile Zones are defined as linear paths through a forested area in which surface and canopy fuels have been altered but where significant overstory is retained to shade the surface fuels. Fires that exhibit flame lengths of less than 4 feet can generally be attacked at the head or flanks by firefighters using hand tools. Handline should be able to hold the fire within the line, and with ladder fuels removed the chance of the fire running into the live tree crowns is greatly reduced as well. Running crown fires lead to unpredictable ember generation (spotting) which can further threaten values at risk.

Therefore, there is a need:

- To create a series of strategically placed DFPZs in order to modify the existing fuels to reduce potential fire behavior to low intensity and reduce the probability of crown fire and spotting.
- To enhance landscape resilience to future wildfires within the Granite Creek watershed.
- To maintain and enhance local communities and economies by providing a diversity of resource management activities, recreational opportunities, commodity outputs, and ecosystem services from public lands.

The overall need for the Ten Cent Community Wildfire Protection Project is to modify the predicted fire behavior in the project area while also supporting local communities by providing goods and services.

Proposed Action

The Forest Service proposes the following actions within the project area to address the purpose and need for action. Multiple types of fuel reduction treatments would occur across these stands and would be designed to increase crown spacing and reduce surface fuels. These treatments would occur along the private land boundaries and extend up to 1.5 miles away from those boundaries, where indicated by predicted fire behavior. The goal would be to create a contiguous DFPZ along all private land borders within the project area. Strategic DFPZs would also be placed along roads and the forest stands within these zones would be treated a maximum of 500 feet from both sides of the road as necessary. The width of treatment would be dictated by current stand conditions as well as other resource management needs. The goal of these roadside treatments would be DFPZs that help facilitate safe evacuation of residents and recreationists in the event of a wildfire, slow the progress of a wildfire coming out of the Wilderness, and provide suppression forces a higher probability of successfully managing a wildfire using indirect or more direct suppression tactics. The proposed actions, with the exception of some prescribed burning, are within 1.5 miles of identified values at risk (cities of Granite and Greenhorn, private inholdings/structures, ingress and egress routes) with most of the treatments occurring within 0.25 miles of the values at risk. The area treated would include 8,137 acres of stands identified that currently support flame lengths greater than or equal to 4 feet and have a high potential for crown fire initiation. A total of 6,035 acres would be treated along egress routes within the project area. About 38,000 acres of prescribed fire is proposed across the watershed including a maximum of about 9,500 acres located in the NFJD Wilderness.

Possible Alternatives

The Forest Service developed 4 alternatives in response to issues raised by the public:

- Alternative 1—No Action
- Alternative 2—Proposed Action

- Alternative 3—First Alternative to the Proposed Action
- Alternative 4—Second Alternative to the Proposed Action

Responsible Official

Ian Reid, District Ranger, North Fork John Day Ranger District will be the responsible official for making the decision and providing direction for the analysis.

Nature of Decision To Be Made

The responsible official will decide whether or not to authorize the proposal.

Preliminary Issues

The Forest Service has identified seven issues from previous scoping:

- Issue 1: Large scale landscape burning may have a negative impact on air quality.
- Issue 2: The prescribed fire treatment proposed in Moist and Cold upland forests (UF) is not appropriate for these Potential Vegetation Groups (PVGs) and associated biophysical environments. These PVGs historically burned at mixed (primarily Moist UF) and high (primarily Cold UF and some Moist UF) severity at the hottest and driest time of the year. Impacts of prescribed burning in the late summer and fall to Moist and Cold UF stands would not be characteristic of these PVGs; as a result, impacts to nutrient cycling, dead wood recruitment, vegetative succession, wildlife species, etc., would also be uncharacteristic.
- Issue 3: Prescribed fire treatments in the Wilderness may have a negative impact on Wilderness characteristics.
- Issue 4: Mechanical treatments need to be prescribed in a manner which maximizes economic benefits.
- Issue 5: Some proposed treatments may be a threat to forest investments such as white pine plantations and Subalpine fir stands.
- Issue 6: Treatment under the Proposed Action would impact the quality of forested stands that provide connectivity between late and old structure and Forest Plan designated old growth habitat at the analysis area and larger landscape scale; treated (mechanical and prescribed fire) connectivity habitat would not meet Forest Plan standards following implementation. The treatment activities would affect the ability of wildlife to move freely between late and old structure and designated old growth stands, and may ultimately impact population levels and the viability of species dependent on old forest habitat.

ADDRESSES: Andrew Stinchfield, Project Manager, P.O. Box 158, Ukiah, OR 97880.

Dated: February 22, 2016.

Ian Reid,

District Ranger.

[FR Doc. 2016–04303 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–11–P

DEPARTMENT OF AGRICULTURE

Rural Business-Cooperative Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Business-Cooperative Service, USDA.

ACTION: Proposed collection; Comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Rural Business-Cooperative Service's intention to request an extension for a currently approved information collection in support of the program for 7 CFR part 4284, subpart F. More specifically, 310B (e) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1932).

DATES: Comments on this notice must be received by May 9, 2016 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: Deputy Administrator, Cooperative Programs, U.S. Department of Agriculture, 1400 Independence Avenue SW., STOP 3250, Washington, DC 20250, Telephone: 202–720–7558.

SUPPLEMENTARY INFORMATION:

Title: Socially Disadvantaged Groups Grant.

OMB Number: 0570–0052.

Expiration Date of Approval: August 31, 2016.

Type of Request: Extension of a currently approved information collection.

Abstract: The purpose of this information collection is to obtain information necessary to evaluate grant applications to determine the eligibility of the applicant and the project for the program and to qualitatively assess the project to determine which projects should be funded.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 1.4 hours per response.

Respondents: Provide technical assistance to socially-disadvantaged groups through eligible cooperatives and cooperative development centers.

Estimated Number of Respondents: 60.

Estimated Number of Responses per Respondent: 6.6.

Estimated Number of Responses: 400.

Estimated Total Annual Burden on Respondents: 575 hours.

Copies of this information collection can be obtained from Jeanne Jacobs, Regulations and Paperwork Management Branch, Support Services Division at (202) 692–0040.

Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Rural Business-Cooperative Service, including whether the information will have practical utility; (b) the accuracy of the Rural Business-Cooperative Service's estimate of the burden of the proposed collection of information including validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments may be sent to Jeanne Jacobs, Regulations and Paperwork Management Branch, Support Services Division, U.S. Department of Agriculture, Rural Development, STOP 0742, 1400 Independence Avenue SW., Washington, DC 20250–0742.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Dated: February 25, 2016.

William C. Smith,

Acting Administrator, Rural Business-Cooperative Service.

[FR Doc. 2016–05057 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–XY–P

DEPARTMENT OF AGRICULTURE

Rural Business-Cooperative Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Business-Cooperative Service.

ACTION: Proposed collection; Comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Rural Business-Cooperative Service's (RBS) intention to

request an extension for a currently approved information collection in support of the program for Business and Industry Guaranteed Loans.

DATES: Comments on this notice must be received by May 9, 2016 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: David Lewis, Business and Industry Loan Servicing Branch, Rural Business-Cooperative Service, Rural Development, U.S. Department of Agriculture, STOP 3224, 1400 Independence Avenue SW., Washington, DC 20250–3224, telephone (202) 690–0797, or by email to *david.lewis@wdc.usda.gov.*

SUPPLEMENTARY INFORMATION: *Title:* Business and Industry Guaranteed Loan Servicing.

OMB Number: 0570–0016.

Expiration Date of Approval: February 29, 2016.

Type of Request: Extension of a currently approved information collection.

Abstract: The purpose of the Business and Industry Guaranteed Loan Program is to improve, develop, or finance business, industry, and employment and to improve the economic and environmental climate in rural communities. This purpose is achieved by bolstering the existing private credit structure through the guarantee of quality loans which will provide lasting community benefits. The information requested is necessary and vital in order for the Agency to make prudent credit and financial decisions.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average .85 hours per response.

Respondents: 4,126.

Estimated Number of Respondents: 4,126.

Estimated Number of Responses per Respondent: 1.

Estimated Number of Responses: 25,807.

Estimated Total Annual Burden on Respondents: 22,246.

Copies of this information collection can be obtained from Kimble Brown, Regulations and Paperwork Management Branch, at (202) 692–0043.

Comments: Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of RBS, including whether the information will have practical utility; (b) the accuracy of RBS's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. Comments may be sent to Kimble Brown, Regulations and Paperwork Management Branch, Rural Development, U.S. Department of Agriculture, STOP 0742, 1400 Independence Avenue SW., Washington, DC 20250–0742.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Dated: February 22, 2016.

William C. Smith,

Acting Administrator, Rural Business-Cooperative Service.

[FR Doc. 2016–05056 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–XY–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Housing Service, USDA.

ACTION: Proposed collection; comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, as amended), this notice announces the Rural Housing Service's intention to request an extension for a currently approved information collection in support of the Single Family Housing Direct Loans and Grants programs. The collection involves the use of Form RD 410–8 ''Applicant Reference Letter.'' The form will be used to obtain information about an applicant's credit history that might not appear on a credit report and to provide clarification on the promptness of applicant's payments on debts which enables Rural Housing Service to make better creditworthiness decisions.

DATES: Comments on this notice must be received by May 9, 2016 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: Antonio Burkett, Loan Specialist, Single Family Housing, Rural Housing Service, U.S. Department of Agriculture, Mail STOP 0783, 1400 Independence Ave. SW., Washington, DC 20250–0783. Phone number: 202–205–3656; fax number: (1) 844–496–7797. Email: *antonio.burkett@wdc.usda.gov.*

SUPPLEMENTARY INFORMATION:

Title: Form RD 410–8, ''Applicant Reference Letter''.

OMB Number: 0575–0091.

Expiration Date of Approval: August 31, 2016.

Type of Request: Extension of a currently approved information collection.

Abstract: The Rural housing Service (RHS) must, by law, make available to the applicant, upon request, the source of information used to make an adverse decision. Individual references may be solicited with the clear understanding that if the information is used to deny credit the information will be made available to the applicant upon request. Without this information, the Agency is unable to determine if a customer would qualify for services.

The burden this form will be accounted for within the individual RD program collection packages using the form. Therefore RD is requesting approval for one respondent and a one hour place holder in order for OMB to issue a control number for this form.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 1 hour per response.

Respondents: Individuals and businesses already extending credit/financing to Section 502 and 504 applicants.

Estimated Number of Respondents: 1.

Estimated Number of Responses per Respondent: 1.

Estimated Number of Responses: 1.

Estimated Total Annual Burden on Respondents: 1.

Copies of this information collection can be obtained from Kimble Brown, Regulations and Paperwork Management Branch, at (202) 692–0043.

Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of Rural Housing Service, including whether the information will have practical utility; (b) the accuracy of Rural Housing Service's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. Comments may be sent to

Kimble Brown, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, Rural Development, STOP 0742, 1400 Independence Ave. SW., Washington, DC 20250.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Dated: February 24, 2016.

Cathy Glover,

Acting Administrator, Rural Housing Service.

[FR Doc. 2016–05058 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–XV–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Housing Service (RHS), USDA.

ACTION: Proposed collection; comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this Notice announces the Rural Housing Service's (RHS) intention to request an extension for a currently approved information collection in support of the program for the Housing Preservation Grant program.

DATES: Comments on this Notice must be received by May 9, 2016 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: Bonnie Edwards-Jackson, Finance and Loan Analyst, Multi-Family Housing Preservation and Direct Loan Division, USDA Rural Development, Stop 0781, 1400 Independence Avenue SW., Washington, DC 20250–0782, telephone (202) 690–0759 (voice) (this is not a toll free number) or (800) 877–8339 (TDD-Federal Information Relay Service) or via email at, *bonnie.edwards@wdc.usda.gov.*

SUPPLEMENTARY INFORMATION:

Title: RHS—Housing Preservation Grant Program.

OMB Number: 0575–0115.

Expiration Date of Approval: July 31, 2016.

Type of Request: Extension of a currently approved information collection.

Abstract: The primary purpose of the Housing Preservation Grant Program is to repair or rehabilitate individual housing, rental properties, or co-ops owned or occupied by very low-and low-income rural persons. Grantees will provide eligible homeowners, owners of rental properties and owners of co-ops with financial assistance through loans, grants, interest reduction payments or other comparable financial assistance for necessary repairs and rehabilitation of dwellings to bring them up to code or minimum property standards. Where repair and rehabilitation assistance is not economically feasible or practical the replacement of existing, individual owner occupied housing is available.

These grants were established by Public Law 98–181, the Housing Urban—Rural Recovery Act of 1983, which amended the Housing Act of 1979 (Pub. L. 93–383) by adding section 533, 42 U.S.C. S 2490(m), Housing Preservation Grants (HPG). In addition, the Secretary of Agriculture has authority to prescribe rules and regulations to implement HPG and other programs under 42 U.S.C. S 1480(j).

Section 533(d) is prescriptive about the information applicants are to submit to RHS as part of their application and in the assessments and criteria RHS is to use in selecting grantees. An applicant is to submit a ''statement of activity'' describing its proposed program, including the specific activities it will undertake, and its schedule. RHS is required in turn to evaluate proposals on a set of prescribed criteria, for which the applicant will also have to provide information, such as: (1) Very low- and low-income persons proposed to be served by the repair and rehabilitation activities; (2) participation by other public and private organizations to leverage funds and lower the cost to the HPG program; (3) the area to be served in terms of population and need: (4) Cost data to assure greatest degree of assistance at lowest cost; (5) administrative capacity of the applicant to carry out the program. The information collected will be the minimum required by law and by necessity for RHS to assure that it funds responsible grantees proposing feasible projects in areas of greatest need. Most data are taken from a localized area, although some are derived from census reports of city, county and Federal Government's showing population and housing characteristics.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average .906 hours per response.

Respondents: A public body or a public or private non-profit corporation.

Estimated Number of Respondents: 1,246.

Estimated Number of Responses per Respondent: 6.683.

Estimated Total Annual Burden on Respondents: 7,544 hours.

Copies of this information collection can be obtained from Jeanne Jacobs, Regulations and Paperwork Management Branch at (202) 692–0040.

Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of RHS, including whether the information will have practical utility; (b) the accuracy of RHS's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments may be sent to Jeanne Jacobs, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, Rural Development, STOP 0742, 1400 Independence Avenue SW., Washington, DC 20250. All responses to this Notice will be summarized and included in the request for OMB approval. All comments will become a matter of public record.

Dated: February 29, 2016.

Tony Hernandez,

Administrator, Rural Housing Service.

[FR Doc. 2016–05055 Filed 3–7–16; 8:45 am]

BILLING CODE 3410–XV–P

DEPARTMENT OF COMMERCE

First Responder Network Authority

National Telecommunications and Information Administration

First Responder Network Authority Board Meetings

AGENCY: First Responder Network Authority (FirstNet), U.S. Department of Commerce.

ACTION: Notice of public meetings.

SUMMARY: The Board of the First Responder Network Authority (FirstNet) will convene an open public teleconference and webinar on March 16, 2016.

DATES: On March 16, 2016, from 12 noon to 4 p.m. EDT, FirstNet's four Board Committees and the full FirstNet Board will hold an open public teleconference and webinar.

ADDRESSES: The meeting will be held via webinar and the link can be found at *http://www.firstnet.gov/content/firstnet-board-meeting-march-16-2016.*

FOR FURTHER INFORMATION CONTACT: Natasha C. Robinson Coates, Senior Counsel, FirstNet, 12201 Sunrise Valley Drive, Mail Stop 243, Reston, Virginia 20192; telephone: (571) 665–6139; email: *natasha.coates@firstnet.gov.* Please direct media inquiries to Ryan Oremland at (571) 665–6186.

SUPPLEMENTARY INFORMATION: This notice informs the public that the Board of FirstNet and the Board Committees will convene an open public meeting on March 16, 2016.

Background: The Middle Class Tax Relief and Job Creation Act of 2012 (Act), Public Law 112–96, 126 Stat. 156 (2012), established FirstNet as an independent authority within the National Telecommunications and Information Administration that is headed by a Board. The Act directs FirstNet to ensure the building, deployment, and operation of a nationwide, interoperable public safety broadband network. The FirstNet Board is responsible for making strategic decisions regarding FirstNet's operations. The FirstNet Board held its first public meeting on September 25, 2012.

Matters to be Considered: FirstNet will post detailed agendas of each meeting on its Web site, *http://www.firstnet.gov,* prior to the meetings. The agenda topics are subject to change. Please note that the subjects that will be discussed by the Committees and the Board may involve commercial or financial information that is privileged or confidential, personnel matters, or other legal matters affecting FirstNet. As such, the Committee chairs and Board Chair may call for a vote to close the meetings only for the time necessary to preserve the confidentiality of such information, pursuant to 47 U.S.C. 1424(e)(2).

Times and Dates of Meetings: On March 16, 2016, from 12 noon to 4 p.m. EDT, FirstNet's four Board Committees and the full FirstNet Board will hold an open public teleconference and webinar.

Place: The meeting will be held via webinar and the link can be found at *http://www.firstnet.gov/content/firstnet-board-meeting-march-16-2016.*

Other Information: These meetings are open to the public and press via teleconference and webcast. In order to get an accurate headcount, all expected attendees are asked to provide notice of intent to attend by sending an email to *BoardRSVP@firstnet.gov.*

The meetings are accessible to people with disabilities. Individuals requiring accommodations, such as sign language interpretation or other ancillary aids, are asked to notify Monica Welham, Executive Assistant, FirstNet, at (571) 665–6144 or *monica.welham@firstnet.gov,* at least five (5) business days before the applicable meeting(s).

The meetings will also be available to interested parties by phone. To be connected to the meetings in listen-only mode by telephone, please dial 800–857–5096 and passcode 4421198.

Records: FirstNet maintains records of all Board proceedings. Minutes of the Board Meeting and the Committee meetings will be available at *www.firstnet.gov.*

Dated: March 3, 2016.

Kris Finney,

Attorney Advisor, First Responder Network Authority.

[FR Doc. 2016–05153 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–TL–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–888]

Floor-Standing, Metal-Top Ironing Tables and Certain Parts Thereof From the People's Republic of China: Continuation of Antidumping Duty Order

AGENCY: Enforcement and Compliance, International Trade Administration, Commerce.

SUMMARY: As a result of determinations by the Department of Commerce (the Department) and the International Trade Commission (the ITC) that revocation of the antidumping duty (AD) order on floor-standing, metal-top ironing tables and certain parts thereof (ironing tables) from the People's Republic of China (PRC) would likely lead to a continuation or recurrence of dumping and material injury to an industry in the United States, the Department is publishing this notice of continuation of the antidumping duty order on ironing tables from the PRC.

DATES: Effective March 8, 2016.

FOR FURTHER INFORMATION CONTACT: Scott Hoefke, AD/CVD Operations, Office VI, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW., Washington, DC 20230; telephone: (202) 482–4947.

SUPPLEMENTARY INFORMATION:

Background

On June 24, 2004, the Department published the final determination in the antidumping duty investigation of ironing tables from the PRC.[1] On August 6, 2004, the Department issued an antidumping duty order on ironing tables from the PRC.[2]

On May 1, 2015, the Department initiated the second five-year (sunset) review of the AD order on ironing tables from the PRC pursuant to section 751(c) of the Tariff Act of 1930, as amended (the Act).[3] As a result of its review, the Department determined that revocation of the Order would likely lead to a continuation or recurrence of dumping and, therefore, notified the ITC of the magnitude of the margins likely to prevail should the order be revoked.[4] On September 28, 2015, the ITC published its determination, pursuant to section 751(c) of the Act, that revocation of the antidumping duty order on ironing tables from the PRC would likely lead to a continuation or recurrence of material injury to an industry in the United States within a reasonably foreseeable time.[5]

Scope of the Order

For purposes of the order, the product covered consists of floor-standing, metal-top ironing tables, assembled or unassembled, complete or incomplete, and certain parts thereof. The subject tables are designed and used principally for the hand ironing or pressing of garments or other articles of fabric. The subject tables have full-height leg assemblies that support the ironing surface at an appropriate (often adjustable) height above the floor. The subject tables are produced in a variety of leg finishes, such as painted, plated, or matte, and they are available with various features, including iron rests, linen racks, and others. The subject

[1] *See Final Determination of Sales at Less Than Fair Value: Floor-Standing, Metal-Top Ironing Tables and Certain Parts Thereof From the People's Republic of China,* 69 FR 35296 (June 24, 2004) (*Final Determination*).

[2] *See Notice of Amended Final Determination of Sales at Less Than Fair Value and Antidumping Duty Order: Floor-Standing, Metal-Top Ironing Tables and Certain Parts Thereof From the People's Republic of China,* 69 FR 47868 (August 6, 2004) (*Order*).

[3] *See Initiation of Five-Year (''Sunset'') Review,* 80 FR 24900 (May 1, 2015).

[4] *See Floor-Standing, Metal-Top Ironing Tables and Certain Parts Thereof From the People's Republic of China: Final Results of the Expedited Sunset Review of the Antidumping Duty Order,* 80 FR 53281 (September 3, 2015) and accompanying Decision Memorandum.

[5] *See Ironing Tables and Certain Parts Thereof From China: Determination,* 80 FR 59815 (October 2, 2015); *see also Ironing Tables and Certain Parts Thereof from China, Inv. No. 731–TA–1047 (Second Review),* USITC Publication 4568 (September 2015).

ironing tables may be sold with or without a pad and/or cover. All types and configurations of floor-standing, metal-top ironing tables are covered by this review.

Furthermore, the order specifically covers imports of ironing tables, assembled or unassembled, complete or incomplete, and certain parts thereof. For purposes of the order, the term ''unassembled'' ironing table means a product requiring the attachment of the leg assembly to the top or the attachment of an included feature such as an iron rest or linen rack. The term ''complete'' ironing table means product sold as a ready-to-use ensemble consisting of the metal-top table and a pad and cover, with or without additional features, *e.g.,* iron rest or linen rack. The term ''incomplete'' ironing table means product shipped or sold as a ''bare board''—*i.e.,* a metal-top table only, without the pad and cover—with or without additional features, *e.g.* iron rest or linen rack. The major parts or components of ironing tables that are intended to be covered by the order under the term ''certain parts thereof'' consist of the metal top component (with or without assembled supports and slides) and/or the leg components, whether or not attached together as a leg assembly. The order covers separately shipped metal top components and leg components, without regard to whether the respective quantities would yield an exact quantity of assembled ironing tables.

Ironing tables without legs (such as models that mount on walls or over doors) are not floor-standing and are specifically excluded. Additionally, tabletop or countertop models with short legs that do not exceed 12 inches in length (and which may or may not collapse or retract) are specifically excluded.

The subject ironing tables were previously classified under Harmonized Tariff Schedule of the United States (HTSUS) subheading 9403.20.0010. Effective July 1, 2003, the subject ironing tables are classified under new HTSUS subheading 9403.20.0011. The subject metal top and leg components are classified under HTSUS subheading 9403.90.8040. Although the HTSUS subheadings are provided for convenience and customs purposes, the Department's written description of the scope is dispositive.

Continuation of the Order

As a result of the determinations by the Department and the ITC that revocation of the AD order would likely lead to a continuation or recurrence of dumping and material injury to an industry in the United States, pursuant to section 751(d)(2) of the Act, the Department hereby gives notice of the continuation of the antidumping duty order on ironing tables from the PRC. U.S. Customs and Border Protection will continue to collect AD cash deposits at the rates in effect at the time of entry for all imports of subject merchandise.

The effective date of the continuation of the Order will be the date of publication in the **Federal Register** of this notice of continuation. Pursuant to section 751(c)(2) of the Act, the Department intends to initiate the next five-year sunset review of the Order not later than 30 days prior to the fifth anniversary of the effective date of continuation.

This five-year (''sunset'') review and this notice are in accordance with section 751(c) of the Act and published pursuant to section 777(i)(1) of the Act.

Dated: March 2, 2016.

Paul Piquado,

Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2016–05172 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

Renewable Energy and Energy Efficiency Advisory Committee

AGENCY: International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of an open meeting.

SUMMARY: The Renewable Energy and Energy Efficiency Advisory Committee (RE&EEAC) will hold a meeting on Tuesday, May 24, 2016 at the U.S. Department of Commerce Herbert C. Hoover Building in Washington, DC. The meeting is open to the public and interested parties are requested to contact the U.S. Department of Commerce in advance of the meeting.

DATES: May 24, 2016, from approximately 8:30 a.m. to 4 p.m. Eastern Standard Time (EST). Members of the public wishing to participate must notify Victoria Gunderson at the contact information below by 5:00 p.m. EST on Friday, May 20, 2016, in order to pre-register.

FOR FURTHER INFORMATION CONTACT: Victoria Gunderson, Designated Federal Officer, Office of Energy and Environmental Industries (OEEI), International Trade Administration, U.S. Department of Commerce at (202) 482–7890; email: *Victoria.Gunderson@trade.gov.*

SUPPLEMENTARY INFORMATION:

Background: The Secretary of Commerce established the RE&EEAC pursuant to his discretionary authority and in accordance with the Federal Advisory Committee Act (5 U.S.C. App.) on July 14, 2010. The RE&EEAC was re-chartered on June 12, 2014. The RE&EEAC provides the Secretary of Commerce with consensus advice from the private sector on the development and administration of programs and policies to enhance the international competitiveness of the U.S. renewable energy and energy efficiency industries.

During the May 24th meeting of the RE&EEAC, committee members will discuss priority issues identified in advance by the Committee Chair and Sub-Committee leadership, hear from Department of Commerce officials and interagency partners on major issues impacting the competitiveness of the U.S. renewable energy and energy efficiency industries, and submit recommendations to the Department of Commerce intended to address these issues.

A limited amount of time before the close of the meeting will be available for pertinent oral comments from members of the public attending the meeting. To accommodate as many speakers as possible, the time for public comments will be limited to two to five minutes per person (depending on number of public participants). Individuals wishing to reserve additional speaking time during the meeting must contact Ms. Gunderson and submit a brief statement of the general nature of the comments, as well as the name and address of the proposed participant by 5:00 p.m. EST on Friday, May 13, 2016. If the number of registrants requesting to make statements is greater than can be reasonably accommodated during the meeting, the International Trade Administration may conduct a lottery to determine the speakers. Speakers are requested to submit a copy of their oral comments by email to Ms. Gunderson for distribution to the participants in advance of the meeting.

Any member of the public may submit pertinent written comments concerning the RE&EEAC's affairs at any time before or after the meeting. Comments may be submitted to the Renewable Energy and Energy Efficiency Advisory Committee, c/o: Victoria Gunderson, Designated Federal Officer, Office of Energy and Environmental Industries, U.S. Department of Commerce; 1401 Constitution Avenue NW.; Mail Stop: 4053; Washington, DC 20230. To be considered during the meeting, written comments must be received no later

than 5:00 p.m. EST on Friday, May 13, 2016, to ensure transmission to the Committee prior to the meeting. Comments received after that date will be distributed to the members but may not be considered at the meeting.

Copies of RE&EEAC meeting minutes will be available within 30 days following the meeting.

Dated: March 2, 2016.

Adam O'Malley,

Director, Office of Energy and Environmental Industries.

[FR Doc. 2016–05189 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–DR–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–821–822]

Certain Cold-Rolled Steel Flat Products from the Russian Federation: Affirmative Preliminary Determination of Sales at Less Than Fair Value, Affirmative Preliminary Determination of Critical Circumstances, and Postponement of Final Determination

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commerce (the ''Department'') preliminarily determines that cold-rolled steel flat products (''cold-rolled steel'') from the Russian Federation (''Russia'') are being, or are likely to be, sold in the United States at less than fair value (''LTFV''), as provided in section 733(b) of the Tariff Act of 1930, as amended (''the Act''). The period of investigation (''POI'') is July 1, 2014, through June 30, 2015. The estimated weighted-average dumping margins of sales at LTFV are shown in the ''Preliminary Determination'' section of this notice. Interested parties are invited to comment on this preliminary determination.

DATES: Effective March 8, 2016.

FOR FURTHER INFORMATION CONTACT: Laurel LaCivita, Eve Wang, or Alex Rosen, AD/CVD Operations, Office III, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW., Washington, DC 20230; telephone: (202) 482–4243, (202) 482–6231, or (202) 482–7814, respectively.

SUPPLEMENTARY INFORMATION:

Background

The Department published the notice of initiation of this investigation on August 24, 2015.[1] For a complete description of the events that followed the initiation of this investigation, see the memorandum that is dated concurrently with this determination and hereby adopted by this notice.[2] A list of topics included in the Preliminary Decision Memorandum is included as Appendix II to this notice. The Preliminary Decision Memorandum is a public document and is on file electronically via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (''ACCESS''). ACCESS is available to registered users at *https://access.trade.gov,* and to all parties in the Central Records Unit, room B8024 of the main Department of Commerce building. In addition, a complete version of the Preliminary Decision Memorandum can be found at *http://enforcement.trade.gov/frn/.* The signed Preliminary Decision Memorandum and the electronic version of the Preliminary Decision Memorandum are identical in content.

As explained in the memorandum from the Acting Assistant Secretary for Enforcement and Compliance, the Department exercised its discretion to toll deadlines as a result of the closure of the Federal Government for Snowstorm Jonas.[3] All deadlines in this segment of the proceeding have been extended by four business days. The revised deadline for the preliminary determination of this investigation is now February 29, 2016.

Scope of the Investigation

The product covered by this investigation is cold-rolled steel from Russia. For a full description of the scope of this investigation, *see* the ''Scope of the Investigation,'' in Appendix I.

Scope Comments

In accordance with the preamble to the Department's regulations,[4] the *Initiation Notice* set aside a period of time for parties to raise issues regarding product coverage (*i.e.,* ''scope'').[5] Certain interested parties commented on the scope of the investigation as it appeared in the *Initiation Notice,* as well as additional language proposed by the Department. For a summary of the product coverage comments and rebuttal responses submitted to the record for this preliminary determination, and accompanying discussion and analysis of all comments timely received, *see* the Preliminary Scope Decision Memorandum.[6] The Department is preliminarily not modifying the scope language as it appeared in the *Initiation Notice.*

Methodology

The Department is conducting this investigation in accordance with section 731 of the Act. Export prices have been calculated in accordance with section 772(a) of the Act. Normal value (''NV'') is calculated in accordance with section 773 of the Act. For a full description of the methodology underlying our preliminary conclusions, *see* the Preliminary Decision Memorandum.

Preliminary Affirmative Determination of Critical Circumstances

On October 30, 2015, Petitioners filed a timely critical circumstances allegation, pursuant to section 773(e)(1) of the Act and 19 CFR 351.206(c)(1), alleging that critical circumstances exist with respect to imports of the merchandise under consideration.[7] In accordance with 19 CFR 351.206(c)(2)(i), when a critical circumstances allegation is submitted more than 20 days before the scheduled date of the preliminary determination, the Department must issue a preliminary finding whether there is a reasonable basis to believe or suspect that critical circumstances exist no later than the date of the preliminary

[1] *See Certain Cold-Rolled Steel Flat Products From Brazil, the People's Republic of China, India, Japan, the Republic of Korea, the Netherlands, the Russian Federation, and the United Kingdom: Initiation of Less-Than-Fair-Value Investigations,* 80 FR 51198 (August 24, 2015) (''*Initiation Notice*'').

[2] *See* Memorandum from Christian Marsh, Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations, to Paul Piquado, Assistant Secretary for Enforcement and Compliance, ''Decision Memorandum for the Preliminary Determination in the Antidumping Duty Investigation of Certain Cold-Rolled Steel Flat Products from the Russian Federation'' (''Preliminary Decision Memorandum''), dated concurrently with this notice.

[3] *See* Memorandum to the file from Ron Lorentzen, Acting Assistant Secretary for Enforcement and Compliance, ''Tolling of Administrative Deadlines as a Result of the Government Closure during Snowstorm 'Jonas,' '' dated January 27, 2016.

[4] *See Antidumping Duties; Countervailing Duties,* 62 FR 27296, 27323 (May 19, 1997).

[5] *See Initiation Notice,* 80 FR at 51199.

[6] *See* Memorandum to Christian Marsh, Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations, ''Certain Cold-Rolled Steel Products From Brazil, the People's Republic of China, India, Japan, the Republic of Korea, the Russian Federation, and the United Kingdom: Scope Comments Decision Memorandum for the Preliminary Determinations'' dated concurrently with this preliminary determination.

[7] *See* letter from Petitioners, ''Certain Cold-Rolled Steel Flat Products From The People's Republic of China, Japan, and the Russian Federation: Petitioners' Critical Circumstances Allegation,'' dated October 30, 2015.

determination. We have conducted an analysis of critical circumstances in accordance with section 733(e) of the Act and 19 CFR 351.206, and preliminarily determine that: (1) There is a history of dumping and material injury by reason of dumped imports in the United States or elsewhere of the subject merchandise in accordance with section 733(e)(1)(A)(i) of the Act; and (2) imports of the subject merchandise have been massive over a relatively short period in accordance with section 733(e)(1)(B) of the Act. Therefore, we preliminarily determine that critical circumstances exist for all Russian producers/exporters of subject merchandise. For a full description of the methodology and results of our analysis, see the Preliminary Decision Memorandum.

All-Others Rate

Section 735(c)(5)(A) of the Act provides that the estimated all-others rate shall be an amount equal to the weighted average of the estimated weighted-average dumping margins established for exporters and producers individually investigated, excluding any zero or *de minimis* margins, and any margins determined entirely under section 776 of the Act. We based our calculation of the all-others rate on the margins calculated for Severstal Export GmbH and PAO Severstal (collectively ''Severstal'') and Novex Trading (Swiss) SA and Novolipetsk Steel OJSC (collectively ''NLMK''), the two mandatory respondents in this investigation.

Preliminary Determination

The Department preliminarily determines that the following estimated weighted-average dumping margins exist:

Exporter/producer	Weighted-average margin (percent)
Severstal Export GmbH and PAO Severstal	12.62
Novex Trading (Swiss) SA and Novolipetsk Steel OJSC	16.89
All Others	14.76

Suspension of Liquidation

In accordance with section 733(d)(2) of the Act, we will direct U.S. Customs and Border Protection (CBP) to suspend liquidation of all entries of cold-rolled steel from Russia as described in the scope of the investigation section entered, or withdrawn from warehouse, for consumption on or after the date of publication of this notice in the **Federal Register**.

Pursuant to section 733 (d)(1)(B) of the Act and 19 CFR 351.205(d), the Department will instruct CBP to require a cash deposit equal to the weighted-average amount by which the NV exceeds U.S. price as indicated in the chart above.[8] These suspension-of-liquidation instructions will remain in effect until further notice.

Section 733(e)(2) of the Act provides that, given an affirmative determination of critical circumstances, any suspension of liquidation shall apply to unliquidated entries of merchandise entered, or withdrawn from warehouse, for consumption on or after the later of (a) the date which is 90 days before the date on which the suspension of liquidation was first ordered, or (b) the date on which notice of initiation of the investigation was published. As described above, we preliminarily find that critical circumstances exist for imports produced or exported by all Russian exporters. Therefore, in accordance with section 733(e)(2)(A) of the Act, the suspension of liquidation shall apply to unliquidated entries of merchandise entered, or withdrawn from warehouse, for consumption on or after the date which is 90 days before the publication of this notice.

Disclosure

We will disclose the calculations performed to interested parties in this proceeding within five days of the date of publication of this notice in accordance with 19 CFR 351.224(b). Interested parties are invited to comment on this preliminary determination. Case briefs or other written comments may be submitted to the Assistant Secretary for Enforcement and Compliance no later than seven days after the date on which the final verification report is issued in this proceeding, and rebuttal briefs, limited to issues raised in case briefs, may be submitted no later than five days after the deadline date for case briefs.[9] Pursuant to 19 CFR 351.309(c)(2) and (d)(2), parties who submit case briefs or rebuttal briefs in this proceeding are encouraged to submit with each argument: (1) A statement of the issue; (2) a brief summary of the argument; and (3) a table of authorities.

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing must submit a written request to the Assistant Secretary for Enforcement and Compliance, U.S. Department of Commerce. All documents must be filed electronically using ACCESS. An electronically-filed request must be received successfully in its entirety by ACCESS by 5:00 p.m. Eastern Time, within 30 days after the date of publication of this notice.[10] Requests should contain the party's name, address, and telephone number, the number of participants, and a list of the issues to be discussed. If a request for a hearing is made, the Department intends to hold the hearing at the U.S. Department of Commerce, 14th Street and Constitution Avenue NW., Washington, DC 20230, at a time and date to be determined. Parties should confirm by telephone the date, time, and location of the hearing two days before the scheduled date.

Verification

As provided in section 782(i) of the Act, we intend to verify information relied upon in making our final determination.

Postponement of Final Determination and Extension of Provisional Measures

Section 735(a)(2) of the Act provides that a final determination may be postponed until not later than 135 days after the date of the publication of the preliminary determination if, in the event of an affirmative preliminary determination, a request for such postponement is made by exporters who account for a significant proportion of exports of the subject merchandise, or in the event of a negative preliminary determination, a request for such postponement is made by Petitioners. 19 CFR 351.210(e)(2) requires that requests by respondents for postponement of a final antidumping determination be accompanied by a request for extension of provisional measures from a four-month period to a period not more than six months in duration.

On February 23, 2016, pursuant to 19 CFR 351.210(b) and (e), Severstal requested that, contingent upon an affirmative preliminary determination of sales at LTFV for the respondents, the Department postpone the final

[8] The Department's companion countervailing duty investigation of cold-rolled steel flat products from the Russian Federation did not find that producers/exporters of covered merchandise received countervailable benefits by virtue of export subsidies. *See Countervailing Duty Investigation of Certain Cold-Rolled Steel Flat Products From the Russian Federation: Preliminary Affirmative Countervailing Duty Determination, Preliminary Negative Critical Circumstances Determination, and Alignment of Final Determination With Final Antidumping Duty Determination,* 80 FR 79564 (December 22, 2015) and accompanying Issues and Decision Memorandum. Therefore, we made no adjustments to the deposit rates for Severstal, NLMK or the companies subject to the all-others rate.

[9] *See* 19 CFR 351.309.

[10] *See* 19 CFR 351.310(c).

determination and that provisional measures be extended to a period not to exceed six months.[11]

In accordance with section 735(a)(2)(A) of the Act and 19 CFR 351.210(b)(2)(ii), because (1) our preliminary determination is affirmative; (2) the requesting exporter accounts for a significant proportion of exports of the subject merchandise; and (3) no compelling reasons for denial exist, we are postponing the final determination and extending the provisional measures from a four-month period to a period not greater than six months. Accordingly, we will make our final determination no later than 135 days after the date of publication of this preliminary determination, pursuant to section 735(a)(2) of the Act.[12]

International Trade Commission (''ITC'') Notification

In accordance with section 733(f) of the Act, we are notifying the ITC of our affirmative preliminary determination of sales at LTFV. If our final determination is affirmative, the ITC will determine before the later of 120 days after the date of this preliminary determination or 45 days after our final determination whether these imports are materially injuring, or threaten material injury to, the U.S. industry.

This determination is issued and published in accordance with sections 733(f) and 777(i)(1) of the Act and 19 CFR 351.205(c).

Dated: February 29, 2016.

Paul Piquado,

Assistant Secretary for Enforcement and Compliance.

Appendix I—Scope of the Investigation

The products covered by this investigation are certain cold-rolled (cold-reduced), flat-rolled steel products, whether or not annealed, painted, varnished, or coated with plastics or other non-metallic substances. The products covered do not include those that are clad, plated, or coated with metal. The products covered include coils that have a width or other lateral measurement (''width'') of 12.7 mm or greater, regardless of form of coil (*e.g.,* in successively superimposed layers, spirally oscillating, etc.). The products covered also include products not in coils (*e.g.,* in straight lengths) of a thickness less than 4.75 mm and a width that is 12.7 mm or greater and that measures at least 10 times the thickness. The products covered also include products not in coils (*e.g.,* in straight lengths) of a thickness of 4.75 mm or more and a width exceeding 150 mm and measuring at least twice the thickness. The products described above may be rectangular, square, circular, or other shape and include products of either rectangular or non-rectangular cross-section where such cross-section is achieved subsequent to the rolling process, *i.e.,* products which have been ''worked after rolling'' (*e.g.,* products which have been beveled or rounded at the edges). For purposes of the width and thickness requirements referenced above:

(1) Where the nominal and actual measurements vary, a product is within the scope if application of either the nominal or actual measurement would place it within the scope based on the definitions set forth above, and

(2) where the width and thickness vary for a specific product (*e.g.,* the thickness of certain products with non-rectangular cross-section, the width of certain products with non-rectangular shape, etc.), the measurement at its greatest width or thickness applies.

Steel products included in the scope of this investigation are products in which: (1) Iron predominates, by weight, over each of the other contained elements; (2) the carbon content is 2 percent or less, by weight; and (3) none of the elements listed below exceeds the quantity, by weight, respectively indicated:

- 2.50 percent of manganese, or
- 3.30 percent of silicon, or
- 1.50 percent of copper, or
- 1.50 percent of aluminum, or
- 1.25 percent of chromium, or
- 0.30 percent of cobalt, or
- 0.40 percent of lead, or
- 2.00 percent of nickel, or
- 0.30 percent of tungsten (also called wolfram), or
- 0.80 percent of molybdenum, or
- 0.10 percent of niobium (also called columbium), or
- 0.30 percent of vanadium, or
- 0.30 percent of zirconium

Unless specifically excluded, products are included in this scope regardless of levels of boron and titanium.

For example, specifically included in this scope are vacuum degassed, fully stabilized (commonly referred to as interstitial-free (IF)) steels, high strength low alloy (HSLA) steels, motor lamination steels, Advanced High Strength Steels (AHSS), and Ultra High Strength Steels (UHSS). IF steels are recognized as low carbon steels with micro-alloying levels of elements such as titanium and/or niobium added to stabilize carbon and nitrogen elements. HSLA steels are recognized as steels with micro-alloying levels of elements such as chromium, copper, niobium, titanium, vanadium, and molybdenum. Motor lamination steels contain micro-alloying levels of elements such as silicon and aluminum. AHSS and UHSS are considered high tensile strength and high elongation steels, although AHSS and UHSS are covered whether or not they are high tensile strength or high elongation steels.

Subject merchandise includes cold-rolled steel that has been further processed in a third country, including but not limited to annealing, tempering, painting, varnishing, trimming, cutting, punching, and/or slitting, or any other processing that would not otherwise remove the merchandise from the scope of the investigation if performed in the country of manufacture of the cold-rolled steel.

All products that meet the written physical description, and in which the chemistry quantities do not exceed any one of the noted element levels listed above, are within the scope of this investigation unless specifically excluded. The following products are outside of and/or specifically excluded from the scope of this investigation:

· Ball bearing steels; [13]

· Tool steels; [14]

· Silico-manganese steel; [15]

· Grain-oriented electrical steels (GOES) as defined in the final determination of the U.S. Department of Commerce in Grain-Oriented Electrical Steel from Germany, Japan, and Poland.[16]

· Non-Oriented Electrical Steels (NOES), as defined in the antidumping orders issued by the U.S. Department of Commerce in Non-Oriented Electrical Steel From the People's Republic of China, Germany, Japan, the Republic of Korea, Sweden, and Taiwan.[17]

[11] *See* Letter from Severstal, ''Certain Cold-Rolled Steel Flat Products from the Russian Federation: Severstal's Request for Postponement of Final Determination,'' dated February 23, 2016.

[12] *See also* 19 CFR 351.210(e).

[13] Ball bearing steels are defined as steels which contain, in addition to iron, each of the following elements by weight in the amount specified: (i) Not less than 0.95 nor more than 1.13 percent of carbon; (ii) not less than 0.22 nor more than 0.48 percent of manganese; (iii) none, or not more than 0.03 percent of sulfur; (iv) none, or not more than 0.03 percent of phosphorus; (v) not less than 0.18 nor more than 0.37 percent of silicon; (vi) not less than 1.25 nor more than 1.65 percent of chromium; (vii) none, or not more than 0.28 percent of nickel; (viii) none, or not more than 0.38 percent of copper; and (ix) none, or not more than 0.09 percent of molybdenum.

[14] Tool steels are defined as steels which contain the following combinations of elements in the quantity by weight respectively indicated: (i) More than 1.2 percent carbon and more than 10.5 percent chromium; or (ii) not less than 0.3 percent carbon and 1.25 percent or more but less than 10.5 percent chromium; or (iii) not less than 0.85 percent carbon and 1 percent to 1.8 percent, inclusive, manganese; or (iv) 0.9 percent to 1.2 percent, inclusive, chromium and 0.9 percent to 1.4 percent, inclusive, molybdenum; or (v) not less than 0.5 percent carbon and not less than 3.5 percent molybdenum; or (vi) not less than 0.5 percent carbon and not less than 5.5 percent tungsten.

[15] Silico-manganese steel is defined as steels containing by weight: (i) Not more than 0.7 percent of carbon; (ii) 0.5 percent or more but not more than 1.9 percent of manganese, and (iii) 0.6 percent or more but not more than 2.3 percent of silicon.

[16] *Grain-Oriented Electrical Steel from Germany, Japan, and Poland: Final Determinations of Sales at Less Than Fair Value and Certain Final Affirmative Determination of Critical Circumstances,* 79 FR 42,501, 42,503 (Dep't of Commerce, July 22, 2014). This determination defines grain-oriented electrical steel as ''a flat-rolled alloy steel product containing by weight at least 0.6 percent but not more than 6 percent of silicon, not more than 0.08 percent of carbon, not more than 1.0 percent of aluminum, and no other element in an amount that would give the steel the characteristics of another alloy steel, in coils or in straight lengths.''

[17] *Non-Oriented Electrical Steel From the People's Republic of China, Germany, Japan, the Republic of Korea, Sweden, and Taiwan: Antidumping Duty Orders,* 79 FR 71,741, 71,741–42 (Dep't of Commerce, Dec. 3, 2014). The orders define NOES as ''cold-rolled, flat-rolled, alloy steel products, whether or not in coils, regardless of width, having

The products subject to this investigation are currently classified in the Harmonized Tariff Schedule of the United States (HTSUS) under item numbers: 7209.15.0000, 7209.16.0030, 7209.16.0060, 7209.16.0070, 7209.16.0091, 7209.17.0030, 7209.17.0060, 7209.17.0070, 7209.17.0091, 7209.18.1530, 7209.18.1560, 7209.18.2510, 7209.18.2520, 7209.18.2580, 7209.18.6020, 7209.18.6090, 7209.25.0000, 7209.26.0000, 7209.27.0000, 7209.28.0000, 7209.90.0000, 7210.70.3000, 7211.23.1500, 7211.23.2000, 7211.23.3000, 7211.23.4500, 7211.23.6030, 7211.23.6060, 7211.23.6090, 7211.29.2030, 7211.29.2090, 7211.29.4500, 7211.29.6030, 7211.29.6080, 7211.90.0000, 7212.40.1000, 7212.40.5000, 7225.50.6000, 7225.50.8080, 7225.99.0090, 7226.92.5000, 7226.92.7050, and 7226.92.8050. The products subject to the investigation may also enter under the following HTSUS numbers: 7210.90.9000, 7212.50.0000, 7215.10.0010, 7215.10.0080, 7215.50.0016, 7215.50.0018, 7215.50.0020, 7215.50.0061, 7215.50.0063, 7215.50.0065, 7215.50.0090, 7215.90.5000, 7217.10.1000, 7217.10.2000, 7217.10.3000, 7217.10.7000, 7217.90.1000, 7217.90.5030, 7217.90.5060, 7217.90.5090, 7225.19.0000, 7226.19.1000, 7226.19.9000, 7226.99.0180, 7228.50.5015, 7228.50.5040, 7228.50.5070, 7228.60.8000, and 7229.90.1000.

The HTSUS subheadings above are provided for convenience and U.S. Customs purposes only. The written description of the scope of the investigation is dispositive.

Appendix II—List of Topics Discussed in the Preliminary Decision Memorandum

I. Summary
II. Background
III. Period of Investigation
IV. Postponement of Final Determination and Extension of Provisional Measures
V. Scope of the Investigation
VI. Preliminary Determination of Critical Circumstances
A. Legal Framework
B. Critical Circumstances Allegation
C. Analysis
VII. Application of Facts Available and Use of Adverse Inferences
VIII. Discussion of Methodology
A. Determination of Comparison Method
B. Results of the Differential Pricing Analysis
IX. Product Comparisons
X. Date of Sale
XI. Export Price
XII. Normal Value
A. Comparison Market Viability
B. Affiliated-Party Transactions and Arm's-Length Test
C. Level of Trade
D. Cost of Production Analysis
1. Calculation of Cost of Production
2. Test of Comparison Market Sale Prices
3. Results of the COP Test
E. Calculation of NV Based on Comparison Market Prices
XIII. Currency Conversion
XIV. U.S. International Trade Commission Notification
XV. Disclosure and Public Comment
XVI. Verification
XVII. Conclusion

[FR Doc. 2016–05000 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–DS–P

an actual thickness of 0.20 mm or more, in which the core loss is substantially equal in any direction of magnetization in the plane of the material. The term 'substantially equal' means that the cross grain direction of core loss is no more than 1.5 times the straight grain direction (*i.e.,* the rolling direction) of core loss. NOES has a magnetic permeability that does not exceed 1.65 Tesla when tested at a field of 800 A/m (equivalent to 10 Oersteds) along (*i.e.,* parallel to) the rolling direction of the sheet (*i.e.,* B800 value). NOES contains by weight more than 1.00 percent of silicon but less than 3.5 percent of silicon, not more than 0.08 percent of carbon, and not more than 1.5 percent of aluminum. NOES has a surface oxide coating, to which an insulation coating may be applied.''

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XE404

Marine Mammals; File No. 18978

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; receipt of application.

SUMMARY: Notice is hereby given that Pam Miller, Alaska Community Action on Toxics, 505 West Northern Lights Blvd., Suite 205, Anchorage, AK 99503, has applied in due form for a permit to receive, import, and export specimens of marine mammals for scientific research.

DATES: Written, telefaxed, or email comments must be received on or before April 7, 2016.

ADDRESSES: The application and related documents are available for review by selecting ''Records Open for Public Comment'' from the ''Features'' box on the Applications and Permits for Protected Species (APPS) home page, *https://apps.nmfs.noaa.gov,* and then selecting File No. 18978 from the list of available applications.

These documents are also available upon written request or by appointment in the Permits and Conservation Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301) 427–8401; fax (301) 713–0376.

Written comments on this application should be submitted to the Chief, Permits and Conservation Division, at the address listed above. Comments may also be submitted by facsimile to (301) 713–0376, or by email to *NMFS.Pr1Comments@noaa.gov.* Please include the File No. 18978 in the subject line of the email comment.

Those individuals requesting a public hearing should submit a written request to the Chief, Permits and Conservation Division at the address listed above. The request should set forth the specific reasons why a hearing on this application would be appropriate.

FOR FURTHER INFORMATION CONTACT: Brendan Hurley or Jennifer Skidmore, (301) 427–8401.

SUPPLEMENTARY INFORMATION: The subject permit is requested under the authority of the Marine Mammal Protection Act of 1972, as amended (MMPA; 16 U.S.C. 1361 *et seq.*), the regulations governing the taking and importing of marine mammals (50 CFR part 216), the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*), and the regulations governing the taking, importing, and exporting of endangered and threatened species (50 CFR 222–226).

The applicant proposes to measure contaminant levels in subsistence-hunted Arctic marine mammals to determine marine mammal exposure to polybrominated diphenyl ethers and perfluorinated compounds. The proposed research will contribute to information about the levels of emerging contaminants in marine mammals. Researchers will work with Yupik households and local hunters to obtain samples from a maximum of 8 animals per year from minke whale (*Balaenoptera acutorostrata*); ringed seal (*Pusa hispida*); bearded seal (*Erignathus barbatus*); and ribbon seal (*Histriophoca fasciata*). A maximum of 9 animals per year are requested from bowhead whale (*Balaena mysticetus*) and spotted seal (*Phoca largha*). Samples would include organs, meat, rendered oils, and blubber. No non-target species will be affected. Samples will come from animals subsistence hunted on St Lawrence Island, AK. The requested permit period is five years.

In compliance with the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), an initial determination has been made that the activity proposed is categorically excluded from the requirement to prepare an environmental assessment or environmental impact statement.

Concurrent with the publication of this notice in the **Federal Register**, NMFS is forwarding copies of the application to the Marine Mammal Commission and its Committee of Scientific Advisors.

Dated: March 2, 2016.

Julia Harrison,

Chief, Permits and Conservation Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2016–05080 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XE478

Identification of Nations Engaged in Illegal, Unreported, or Unregulated Fishing, Bycatch, or Shark Fishing

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; request for information.

SUMMARY: NMFS is seeking information regarding nations whose vessels are engaged in illegal, unreported, or unregulated (IUU) fishing, bycatch of protected living marine resources (PLMRs), and/or fishing activities in waters beyond any national jurisdiction that target or incidentally catch sharks. Such information will be reviewed for the purposes of the identification of nations pursuant to the High Seas Driftnet Fishing Moratorium Protection Act (Moratorium Protection Act).

DATES: Information should be received on or before May 31, 2016. A public webinar will take place from 3 to 4:30 p.m. eastern daylight saving time on April 22, 2016.

ADDRESSES: Information may be submitted to either by mail to: NMFS Office of International Affairs and Seafood Inspection, Attn.: MSRA Information, F/IS 1315 East-West Highway, Silver Spring, MD 20910, or electronically to: *IUU.PLMR.Sharks@noaa.gov.* Information on how to participate in the April 22, 2016, public webinar will be posted online at *http://www.nmfs.noaa.gov/ia/.*

FOR FURTHER INFORMATION CONTACT: Kristin Rusello, phone 301–427–8376, or email *kristin.rusello@noaa.gov.*

SUPPLEMENTARY INFORMATION: The Shark Conservation Act of 2010 (Pub. L. 111–348) amended the Moratorium Protection Act by requiring that actions be taken by the United States to strengthen shark conservation. In November 2015, the Illegal, Unreported, and Unregulated Fishing Enforcement Act of 2015 (IUUFEA) (Pub. L. 114–81) further amended the Moratorium Protection Act by, among other things, expanding the scope of information that can be used for the identification of nations to three years for the IUU fishing and bycatch provisions.

Specifically, the Moratorium Protection Act requires the Secretary of Commerce (Secretary) to identify in a biennial report to Congress those nations whose fishing vessels are engaged, or have been engaged at any point during the preceding three years, in IUU fishing. The definition of IUU fishing can be found at 50 CFR 300.201 and includes:

(1) Fishing activities that violate conservation and management measures required under an international fishery management agreement to which the United States is a party, including catch limits or quotas, capacity restrictions, bycatch reduction requirements, shark conservation measures, and data reporting;

(2) In the case of non-parties to an international fishery management agreement to which the United States is a party, fishing activities that would undermine the conservation of the resources managed under that agreement;

(3) Overfishing of fish stocks shared by the United States, for which there are no applicable international conservation or management measures or in areas with no applicable international fishery management organization or agreement, that has adverse impacts on such stocks;

(4) Fishing activity that has an adverse impact on vulnerable marine ecosystems such as seamounts, hydrothermal vents, cold water corals and other vulnerable marine ecosystems located beyond any national jurisdiction, for which there are no applicable conservation or management measures or in areas with no applicable international fishery management organization or agreement; and

(5) Fishing activities by foreign flagged vessels in U.S. waters without authorization of the United States.

In addition, the Secretary must identify in the biennial report those nations whose fishing vessels are engaged, or have been engaged at any point during the preceding three years in fishing activities in waters beyond any national jurisdiction that result in bycatch of a PLMR, or beyond the U.S. exclusive economic zone (EEZ) that result in bycatch of a PLMR shared by the United States, and that have not implemented measures to address that bycatch that are comparable in effectiveness to U.S. regulatory requirements. In this context, PLMRs are defined as non-target fish, sea turtles, sharks, or marine mammals that are protected under U.S. law or international agreement, including the Marine Mammal Protection Act, the Endangered Species Act, the Shark Finning Prohibition Act, and the Convention on International Trade in Endangered Species of Wild Flora and Fauna. PLMRs do not include species, except sharks, managed under the Magnuson-Stevens Fishery Conservation and Management Act, the Atlantic Tunas Convention Act, or any international fishery management agreement. A list of species considered as PLMRs for this purpose is available online at: *http://www.nmfs.noaa.gov/msa2007/docs/list_of_protected_lmr_act_022610.pdf.*

Furthermore, the Shark Conservation Act requires that the Secretary of Commerce identify nations in a biennial report to Congress whose fishing vessels are engaged, or have been engaged during the calendar year prior to the biennial report in fishing activities or practices in waters beyond any national jurisdiction that target or incidentally catch sharks and the nation has not adopted a regulatory program to provide for the conservation of sharks, including measures to prohibit removal of any of the fins of a shark (including the tail) and discarding the carcass of the shark at sea, that is comparable to that of the United States, taking into account different conditions.

More information regarding the identification process and how the information received will be used in that process can be found in the regulations codified at 50 CFR 300.200. Note that the timeframe for activities to be considered for IUU fishing and bycatch identifications has not been changed to reflect the amendments in the IUUFEA to three years each.

The fourth biennial report to Congress was submitted in February 2015 and is available online at: *http://www.nmfs.noaa.gov/ia/iuu/msra_page/2015noaareptcongress.pdf.* The report identified six nations for IUU fishing.

In fulfillment of its requirements under the Moratorium Protection Act, NMFS is preparing the fifth biennial report to Congress, which will identify nations whose fishing vessels are engaged in IUU fishing or fishing practices that result in bycatch of PLMRs, shark catch in waters beyond any national jurisdiction without a regulatory program comparable to the United States. NMFS is soliciting information from the public that could assist in its identification of nations engaged in activities that meet the criteria described above for IUU fishing, PLMR bycatch, or shark catch in waters beyond any national jurisdiction. Some

types of information that may prove useful to NMFS include:

- Documentation (photographs, etc.) of IUU activity or fishing vessels engaged in PLMR bycatch or catch of sharks on the high seas;
- Documentation (photographs, etc.) of fishing vessels engaged in shared PLMR bycatch in any waters beyond the U.S. EEZ;
- Fishing vessel records;
- Trade data supporting evidence that a nation's vessels are engaged in shark catch on the high seas;
- Reports from off-loading facilities, port-side government officials, enforcement agents, military personnel, port inspectors, transshipment vessel workers and fish importers;
- Sightings of vessels included on RFMO IUU vessel lists;
- RFMO catch documents and statistical document programs;
- Nation's domestic regulations for bycatch and shark conservation and management;
- Action or inaction at the national level, resulting in non-compliance with RFMO conservation and management measures, such as exceeding quotas or catch limits, or failing to report or misreporting data of the nation's fishing activities; and
- Reports from governments, international organizations, or nongovernmental organizations.

NMFS will consider all available information, as appropriate, when making a determination whether or not to identify a particular nation in the biennial report to Congress. As stated previously, NMFS is limited in the data it may use as the basis of a nation's identification. This information includes IUU fishing activity and bycatch of PLMRs in 2014, 2015 and 2016, and shark fishing activity in waters beyond any national jurisdiction in 2016. Information should be as specific as possible as this will assist NMFS in its review. NMFS will consider several criteria when determining whether information is appropriate for use in making identifications, including:

- Corroboration of information;
- Whether multiple sources have been able to provide information in support of an identification;
- The methodology used to collect the information;
- Specificity of the information provided;
- Susceptibility of the information to falsification and alteration; and
- Credibility of the individuals or organization providing the information.

Dated: March 3, 2016.

John Henderschedt,

Director, Office of International Affairs and Seafood Inspection, National Marine Fisheries Service.

[FR Doc. 2016–05156 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XE469

Endangered Species; File No. 19627

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; receipt of application.

SUMMARY: Notice is hereby given that the NMFS Southeast Fisheries Science Center, 75 Virginia Beach Drive, Room 207, Miami, FL 33149 [Responsible Party: Dr. Bonnie Ponwith, Ph.D.], has applied in due form for a permit to take loggerhead (*Caretta caretta*), green (*Chelonia mydas*), Kemp's ridley (*Lepidochelys kempii*), hawksbill (*Eretmochelys imbricata*), leatherback (*Dermochelys coriacea*), and unidentified hardshell sea turtles for purposes of scientific research.

DATES: Written, telefaxed, or email comments must be received on or before April 7, 2016.

ADDRESSES: The application and related documents are available for review by selecting ''Records Open for Public Comment'' from the ''Features'' box on the Applications and Permits for Protected Species (APPS) home page, *https://apps.nmfs.noaa.gov,* and then selecting File No. 19627 from the list of available applications.

These documents are also available upon written request or by appointment in the Permits and Conservation Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301) 427–8401; fax (301) 713–0376.

Written comments on this application should be submitted to the Chief, Permits and Conservation Division, at the address listed above. Comments may also be submitted by facsimile to (301) 713–0376, or by email to *NMFS.Pr1Comments@noaa.gov.* Please include the File No. in the subject line of the email comment.

Those individuals requesting a public hearing should submit a written request to the Chief, Permits and Conservation Division at the address listed above. The request should set forth the specific reasons why a hearing on this application would be appropriate.

FOR FURTHER INFORMATION CONTACT: Arturo Herrera or Amy Hapeman, (301) 427–8401.

SUPPLEMENTARY INFORMATION: The subject permit is requested under the authority of the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*) and the regulations governing the taking, importing, and exporting of endangered and threatened species (50 CFR parts 222–226).

The applicant requests a five-year permit to research sea turtles that interact with commercialfisheries and other authorized activities in the Gulf of Mexico and East Coast of the United States. The purpose of the project is to: (1) Monitor the take of sea turtles by observed fisheries, (2) collect data that can enhance efforts to estimate total bycatch and the effects of bycatch on the sea turtle subpopulations, (3) and document interactions at various life stages to help in the recovery process of these species. Researchers would be authorized to handle, photograph, measure, weigh, flipper and passive integrated transponder tag, tissue sample, temporary carapace mark, and salvage specimens legally taken during commercial fishing activities. Up to 86 green, 571 loggerhead, 165 Kemp's ridley, 77 hawksbill, 253 leatherback, 20 olive ridley, and 14 unidentified sea turtles would be sampled annually.

Dated: March 2, 2016.

Julia Harrison,

Chief, Permits and Conservation Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2016–05079 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Proposed Information Collection; Comment Request; Coastal Ocean Program Grants Proposal Application Package

AGENCY: National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice.

SUMMARY: The Department of Commerce, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information

collections, as required by the Paperwork Reduction Act of 1995.

DATES: Written comments must be submitted on or before May 9, 2016.

ADDRESSES: Direct all written comments to Jennifer Jessup, Departmental Paperwork Clearance Officer, Department of Commerce, Room 6616, 14th and Constitution Avenue NW., Washington, DC 20230 (or via the Internet at *JJessup@doc.gov).*

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument and instructions should be directed to Laurie Golden, 240–533–0285 or *laurie.golden@noaa.gov.*

SUPPLEMENTARY INFORMATION:

I. Abstract

This request is for a revision and extension of a currently approved information collection. The National Oceanic and Atmospheric Administration's Coastal Ocean Program (COP) provides direct financial assistance through grants and cooperative agreements for research supporting the management of coastal ecosystems. The statutory authority for COP is Public Law 102–567 section 201 (Coastal Ocean Program). In addition to standard government application requirements, applicants for financial assistance are required to submit a project summary form, current and pending form and a key contacts form. Recipients are required to file annual progress reports and a project final report using COP formats. All of these requirements are needed for better evaluation of proposals and monitoring of awards.

This request is for a revision due to the addition of the NOAA RESTORE Act Science Program. This program provides direct financial assistance through grants and cooperative agreements for research, observation, and monitoring to support, to the maximum extent practicable, the long-term sustainability of the ecosystem, fish stocks, fish habitat, and the recreational, commercial, and charter-fishing industry in the Gulf of Mexico. NOAA was authorized to establish and administer the Program, in consultation with the U.S. Fish and Wildlife Service, by the Resources and Ecosystems Sustainability, Tourist Opportunities, and Revived Economies (RESTORE) of the Gulf States Act of 2012 (Pub. L. 112–141, section 1604). Identified in the RESTORE Act as the Gulf Coast Ecosystem Restoration Science, Observation, Monitoring, and Technology Program, the Program is commonly known as the NOAA RESTORE Act Science Program. The NOAA RESTORE Act Science Program will use the standard government application forms for financial assistance as well as the COP project summary form, current and pending form and a key contacts form. Recipients are required to file semi-annual progress reports and a project final report using a revised COP format. These additional forms are necessary for consistency. The main purpose of this information collection is to enable the NOAA RESTORE Act Science Program to provide summaries of each proposed project, the key applicant contact information and their current and pending Federal funding. The information gathered will enable the NOAA RESTORE Act Science Program to properly and quickly evaluate proposals in a collaborative environment with its partner agencies.

II. Method of Collection

Respondents have a choice of either electronic or paper forms.

III. Data

OMB Control Number: 0648–0384.

Form Number: None.

Type of Review: Regular submission (revision/extension of a currently approved collection).

Affected Public: Non-profit institutions; State, local, or tribal government; business or other for-profit organizations.

Estimated Number of Respondents: 508.

Estimated Time per Response: 30 minutes each for a project summary, key contacts and current and pending federal support; 5 hours for a semi-annual report; 5 hours for an annual report and 10 hours for a final report.

Estimated Total Annual Burden Hours: 1,920.

Estimated Total Annual Cost to Public: $0 in recordkeeping/reporting costs.

IV. Request for Comments

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and cost) of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

Dated: March 2, 2016.

Sarah Brabson,

NOAA PRA Clearance Officer.

[FR Doc. 2016–05011 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–JS–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XE433

Schedules for Atlantic Shark Identification Workshops and Protected Species Safe Handling, Release, and Identification Workshops

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public workshops.

SUMMARY: Free Atlantic Shark Identification Workshops and Protected Species Safe Handling, Release, and Identification Workshops will be held in April, May, and June of 2016. Certain fishermen and shark dealers are required to attend a workshop to meet regulatory requirements and to maintain valid permits. Specifically, the Atlantic Shark Identification Workshop is mandatory for all federally permitted Atlantic shark dealers. The Protected Species Safe Handling, Release, and Identification Workshop is mandatory for vessel owners and operators who use bottom longline, pelagic longline, or gillnet gear, and who have also been issued shark or swordfish limited access permits. Additional free workshops will be conducted during 2016 and will be announced in a future notice.

DATES: The Atlantic Shark Identification Workshops will be held on April 7, May 12, and June 9, 2016.

The Protected Species Safe Handling, Release, and Identification Workshops will be held on April 12, April 29, May 25, May 27, June 10, and June 15, 2016.

See **SUPPLEMENTARY INFORMATION** for further details.

ADDRESSES: The Atlantic Shark Identification Workshops will be held in Wilmington, NC; Bohemia, NY; and Manahawkin, NJ.

The Protected Species Safe Handling, Release, and Identification Workshops

will be held in Revere, MA; Gulfport, MS; Kitty Hawk, NC; Port St. Lucie, FL; Manahawkin, NJ; and Ocean City, MD.

See **SUPPLEMENTARY INFORMATION** for further details on workshop locations.

FOR FURTHER INFORMATION CONTACT: Rick Pearson by phone: (727) 824–5399, or by fax: (727) 824–5398.

SUPPLEMENTARY INFORMATION: The workshop schedules, registration information, and a list of frequently asked questions regarding these workshops are posted on the Internet at: *http://www.nmfs.noaa.gov/sfa/hms/compliance/workshops/index.html.*

Atlantic Shark Identification Workshops

Since January 1, 2008, Atlantic shark dealers have been prohibited from receiving, purchasing, trading, or bartering for Atlantic sharks unless a valid Atlantic Shark Identification Workshop certificate is on the premises of each business listed under the shark dealer permit that first receives Atlantic sharks (71 FR 58057; October 2, 2006). Dealers who attend and successfully complete a workshop are issued a certificate for each place of business that is permitted to receive sharks. These certificate(s) are valid for 3 years. Approximately 119 free Atlantic Shark Identification Workshops have been conducted since January 2007.

Currently, permitted dealers may send a proxy to an Atlantic Shark Identification Workshop. However, if a dealer opts to send a proxy, the dealer must designate a proxy for each place of business covered by the dealer's permit which first receives Atlantic sharks. Only one certificate will be issued to each proxy. A proxy must be a person who is currently employed by a place of business covered by the dealer's permit; is a primary participant in the identification, weighing, and/or first receipt of fish as they are offloaded from a vessel; and who fills out dealer reports. Atlantic shark dealers are prohibited from renewing a Federal shark dealer permit unless a valid Atlantic Shark Identification Workshop certificate for each business location that first receives Atlantic sharks has been submitted with the permit renewal application. Additionally, trucks or other conveyances that are extensions of a dealer's place of business must possess a copy of a valid dealer or proxy Atlantic Shark Identification Workshop certificate.

Workshop Dates, Times, and Locations

1. April 7, 2016, 12 p.m.–4 p.m., Hampton Inn, 124 Old Eastwood Road, Wilmington, NC 28403.

2. May 12, 2016, 12 p.m.–4 p.m., LaQuinta Inn & Suites, 10 Aero Road, Bohemia, NY 11716.

3. June 9, 2016, 12 p.m.–4 p.m., Holiday Inn, 151 Route 72 East, Manahawkin, NJ 08050.

Registration

To register for a scheduled Atlantic Shark Identification Workshop, please contact Eric Sander at *ericssharkguide@yahoo.com* or at (386) 852–8588.

Registration Materials

To ensure that workshop certificates are linked to the correct permits, participants will need to bring the following specific items to the workshop:

- Atlantic shark dealer permit holders must bring proof that the attendee is an owner or agent of the business (such as articles of incorporation), a copy of the applicable permit, and proof of identification.
- Atlantic shark dealer proxies must bring documentation from the permitted dealer acknowledging that the proxy is attending the workshop on behalf of the permitted Atlantic shark dealer for a specific business location, a copy of the appropriate valid permit, and proof of identification.

Workshop Objectives

The Atlantic Shark Identification Workshops are designed to reduce the number of unknown and improperly identified sharks reported in the dealer reporting form and increase the accuracy of species-specific dealer-reported information. Reducing the number of unknown and improperly identified sharks will improve quota monitoring and the data used in stock assessments. These workshops will train shark dealer permit holders or their proxies to properly identify Atlantic shark carcasses.

Protected Species Safe Handling, Release, and Identification Workshops

Since January 1, 2007, shark limited-access and swordfish limited-access permit holders who fish with longline or gillnet gear have been required to submit a copy of their Protected Species Safe Handling, Release, and Identification Workshop certificate in order to renew either permit (71 FR 58057; October 2, 2006). These certificate(s) are valid for 3 years. As such, vessel owners who have not already attended a workshop and received a NMFS certificate, or vessel owners whose certificate(s) will expire prior to the next permit renewal, must attend a workshop to fish with, or renew, their swordfish and shark limited-access permits. Additionally, new shark and swordfish limited-access permit applicants who intend to fish with longline or gillnet gear must attend a Protected Species Safe Handling, Release, and Identification Workshop and submit a copy of their workshop certificate before either of the permits will be issued. Approximately 226 free Protected Species Safe Handling, Release, and Identification Workshops have been conducted since 2006.

In addition to certifying vessel owners, at least one operator on board vessels issued a limited-access swordfish or shark permit that uses longline or gillnet gear is required to attend a Protected Species Safe Handling, Release, and Identification Workshop and receive a certificate. Vessels that have been issued a limited-access swordfish or shark permit and that use longline or gillnet gear may not fish unless both the vessel owner and operator have valid workshop certificates onboard at all times. Vessel operators who have not already attended a workshop and received a NMFS certificate, or vessel operators whose certificate(s) will expire prior to their next fishing trip, must attend a workshop to operate a vessel with swordfish and shark limited-access permits that uses longline or gillnet gear.

Workshop Dates, Times, and Locations

1. April 12, 2016, 9 a.m.–5 p.m., Hampton Inn, 230 Lee Burbank Highway, Revere, MA 02151.

2. April 29, 2016, 9 a.m.–5 p.m., Holiday Inn, 9515 Highway 49, Gulfport, MS 39503.

3. May 25, 2016, 9 a.m.–5 p.m., Hilton Garden Inn, 5353 North Virginia Dare Trail, Kitty Hawk, NC 27949.

4. May 27, 2016, 9 a.m.–5 p.m., Holiday Inn, 10120 South Federal Highway, Port St. Lucie, FL 34952.

5. June 10, 2016, 9 a.m.–5 p.m., Holiday Inn, 151 Route 72, Manahawkin, NJ 08050.

6. June 15, 2016, 9 a.m.–5 p.m., Holiday Inn, 6600 Coastal Highway, Ocean City, MD 21842.

Registration

To register for a scheduled Protected Species Safe Handling, Release, and Identification Workshop, please contact Angler Conservation Education at (386) 682–0158.

Registration Materials

To ensure that workshop certificates are linked to the correct permits, participants will need to bring the following specific items with them to the workshop:

• Individual vessel owners must bring a copy of the appropriate swordfish and/or shark permit(s), a copy of the vessel registration or documentation, and proof of identification.

• Representatives of a business-owned or co-owned vessel must bring proof that the individual is an agent of the business (such as articles of incorporation), a copy of the applicable swordfish and/or shark permit(s), and proof of identification.

• Vessel operators must bring proof of identification.

Workshop Objectives

The Protected Species Safe Handling, Release, and Identification Workshops are designed to teach longline and gillnet fishermen the required techniques for the safe handling and release of entangled and/or hooked protected species, such as sea turtles, marine mammals, and smalltooth sawfish. In an effort to improve reporting, the proper identification of protected species will also be taught at these workshops. Additionally, individuals attending these workshops will gain a better understanding of the requirements for participating in these fisheries. The overall goal of these workshops is to provide participants with the skills needed to reduce the mortality of protected species, which may prevent additional regulations on these fisheries in the future.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: March 3, 2016.

Emily H. Menashes,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2016–05131 Filed 3–7–16; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DoD–2015–OS–0143]

Agency Information Collection Activities: Submission for OMB Review; Comment Request; Fast Track Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery

AGENCY: Department of Defense.

ACTION: 30-day notice of submission of information collection approval from the Office of Management and Budget and request for comments.

SUMMARY: As part of a Federal Government-wide effort to streamline the process to seek feedback from the public on service delivery, the Office of the Secretary has submitted a Generic Information Collection Request (Generic ICR): ''Fast Track Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery'' to OMB for approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*).

DATES: Comments must be submitted by April 7, 2016.

FOR FURTHER INFORMATION CONTACT: Frederick Licari, 571–372–0493.

SUPPLEMENTARY INFORMATION:

Title: Fast Track Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

Abstract: The information collection activity will garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. By qualitative feedback we mean information that provides useful insights on perceptions and opinions, but are not statistical surveys that yield quantitative results that can be generalized to the population of study. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communications between the Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

Feedback collected under this generic clearance will provide useful information, but it will not yield data that can be generalized to the overall population. This type of generic clearance for qualitative information will not be used for quantitative information collections that are designed to yield reliably actionable results, such as monitoring trends over time or documenting program performance. Such data uses require more rigorous designs that address: The target population to which generalizations will be made, the sampling frame, the sample design (including stratification and clustering), the precision requirements or power calculations that justify the proposed sample size, the expected response rate, methods for assessing potential non-response bias, the protocols for data collection, and any testing procedures that were or will be undertaken prior to fielding the study. Depending on the degree of influence the results are likely to have, such collections may still be eligible for submission for other generic mechanisms that are designed to yield quantitative results.

The Agency did not receive any comments in response to the 60-day notice published in the **Federal Register** on December 31, 2015 (80 FR 81813–81815).

Current Actions: Processing a new Fast Track Generic.

Type of Review: New Collection.

Affected Public: Individuals or Households.

Respondent's Obligation: Voluntary.

Estimated Number of Respondents: 100,000.

Below we provide projected average estimates for the next three years:

Average Expected Annual Number of Activities: 100.

Average Number of Respondents per Activity: 1000.

Responses per Respondent: 1.

Annual responses: 100,000.

Frequency of Response: On Occasion.

Average minutes per response: 10 minutes.

Burden hours: 16,667 hours.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget control number.

OMB Desk Officer: Ms. Jasmeet Seehra.

Comments and recommendations on the proposed information collection should be emailed to Ms. Jasmeet Seehra, DoD Desk Officer, at *Oira_submission@omb.eop.gov.* Please identify the proposed information collection by DoD Desk Officer and the Docket ID number and title of the information collection.

You may also submit comments and recommendations, identified by Docket ID number and title, by the following method:

• Federal eRulemaking Portal: *http://www.regulations.gov.* Follow the instructions for submitting comments.

Instructions: All submissions received must include the agency name, Docket ID number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

DOD Clearance Officer: Mr. Frederick Licari.

Written requests for copies of the information collection proposal should

be sent to Mr. Licari at WHS/ESD Directives Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350–3100.

Dated: March 3, 2016.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2016–05101 Filed 3–7–16; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

[Docket No.: ED–2016–ICCD–0001]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Private School Universe Survey (PSS) June 2016–May 2019

AGENCY: National Center for Education Statistics (NCES), Department of Education (ED).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 3501 *et seq.*), ED is proposing a revision of an existing information collection.

DATES: Interested persons are invited to submit comments on or before April 7, 2016.

ADDRESSES: To access and review all the documents related to the information collection listed in this notice, please use *http://www.regulations.gov* by searching the Docket ID number ED–2016–ICCD–0001. Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting the Docket ID number or via postal mail, commercial delivery, or hand delivery. *Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted.* Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Room 2E–103, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Kashka Kubzdela at *kashka.kubzdela@ed.gov.*

SUPPLEMENTARY INFORMATION: The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: Private School Universe Survey (PSS) June 2016–May 2019.

OMB Control Number: 1850–0641.

Type of Review: A revision of an existing information collection.

Respondents/Affected Public: Individuals and Households.

Total Estimated Number of Annual Responses: 48,400.

Total Estimated Number of Annual Burden Hours: 10,260.

Abstract: The Private School Universe Survey (PSS) is conducted by the National Center for Education Statistics (NCES) to collect basic information from the universe of private elementary and secondary schools in the United States. The PSS is designed to gather biennial data on the total number of private schools, teachers, and students, along with a variety of related data, including: Religious orientation; grade-levels taught and size of school; length of school year and of school day; total student enrollment by gender (K–12); number of high school graduates; whether a school is single-sexed or coeducational; number of teachers employed; program emphasis; and existence and type of its kindergarten program. The PSS includes all schools that are not supported primarily by public funds, that provide classroom instruction for one or more of grades K–12 or comparable ungraded levels, and that have one or more teachers. No substantive changes have been made to the survey or its procedures since its last approved administration (OMB# 1850–0641 v.6–7). The PSS is also used to create a universe list of private schools for use as a sampling frame for NCES surveys of private schools. This request is to conduct the 2017–18 Private School Universe Survey (PSS) data collection and the 2017–18 and 2019–20 PSS frame-development activities.

Dated: March 3, 2016.

Stephanie Valentine,

Acting Director, Information Collection Clearance Division, Privacy, Information and Records Management Services, Office of Management.

[FR Doc. 2016–05139 Filed 3–7–16; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket ID ED–2016–FSA–0014]

Privacy Act of 1974; System of Records

AGENCY: Federal Student Aid, Department of Education.

ACTION: Notice of an altered system of records.

SUMMARY: In accordance with the Privacy Act of 1974, as amended (Privacy Act), 5 U.S.C. 552a, the Chief Operating Officer, Federal Student Aid, of the U.S. Department of Education (Department) publishes this notice proposing an altered system of records for the Office of the Student Loan Ombudsman Records (18–11–11).

The Department created the Office of the Student Loan Ombudsman Records system to support the administration of title IV of the Higher Education Act of 1965, as amended (HEA); to receive, review, and attempt to resolve complaints from customers of Federal Student Aid programs, and to resolve such complaints within the Department and with institutions of higher education, lenders, guaranty agencies, loan servicers, and other participants in the loan programs; and to compile and analyze data on borrower complaints and make appropriate recommendations.

The Department seeks comments on the altered system of records described in this notice, in accordance with the requirements of the Privacy Act.

DATES: Submit your comments on this notice of an altered system of records on or before April 7, 2016.

The Department filed a report describing the altered system of records covered by this notice with the Chair of the Senate Committee on Homeland

Security and Governmental Affairs, the Chair of the House Committee on Oversight and Government Reform, and the Administrator of the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), on February 23, 2016. This altered system of records will become effective on the later date of: (1) The expiration of the 40-day period for OMB review on April 4, 2016, unless OMB waives 10 days of the 40-day review period for compelling reasons shown by the Department; or (2) April 7, 2016, unless the system of records requires changes as a result of public comment or OMB review. The Department will publish any changes to the altered system of records resulting from public comment or OMB review.

ADDRESSES: Submit your comments through the Federal eRulemaking Portal or via postal mail, commercial delivery, or hand delivery. We will not accept comments submitted by fax or by email or those submitted after the comment period. To ensure that we do not receive duplicate copies, please submit your comments only once. In addition, please include the Docket ID and the term ''Office of the Student Loan Ombudsman Records'' at the top of your comments.

- *Federal eRulemaking Portal:* Go to *www.regulations.gov* to submit your comments electronically. Information on using Regulations.gov, including instructions for accessing agency documents, submitting comments, and viewing the docket, is available on the site under the ''Help'' tab.
- *Postal Mail, Commercial Delivery, or Hand Delivery:* If you mail or deliver your comments about this system of records, address them to: Joyce DeMoss, Ombudsman/Director, Ombudsman Group, Customer Experience, Federal Student Aid, U.S. Department of Education, 830 First Street NE., 4th Floor/MC–5144, Union Center Plaza (UCP), Washington, DC 20202–5144. Telephone: (202) 377–3992.

Privacy Note: The Department's policy is to make all comments received from members of the public available for public viewing in their entirety on the Federal eRulemaking Portal at *www.regulations.gov.* Therefore, commenters should be careful to include in their comments only information that they wish to make publicly available.

Assistance to Individuals with Disabilities in Reviewing the Rulemaking Record: On request, we will provide an appropriate accommodation or auxiliary aid to an individual with a disability who needs assistance to review the comments or other documents in the public rulemaking record for this notice. If you want to schedule an appointment for this type of accommodation or auxiliary aid, please contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

FOR FURTHER INFORMATION CONTACT: Ombudsman/Director, Ombudsman Group, Customer Experience, Federal Student Aid, U.S. Department of Education, 830 First Street NE., 4th Floor/MC–5144, Union Center Plaza (UCP), Washington, DC 20202–5144. Telephone: (202) 377–3992.

If you use a telecommunications device for the deaf or text telephone, call the Federal Relay Service, toll free, at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (*e.g.,* braille, large print, audiotape, or compact disc) on request to the contact person listed in this section.

SUPPLEMENTARY INFORMATION:

Preamble

The Privacy Act (5 U.S.C. 552a (e)(4) and (11)) requires the Department to publish in the **Federal Register** this notice of an altered system of records. The Department's regulations implementing the Privacy Act are contained in the Code of Federal Regulations (CFR) in 34 CFR part 5b.

The Privacy Act applies to information about an individual that is maintained in a system of records from which information is retrieved by a unique identifier associated with the individual, such as a name or Social Security number (SSN). The information about the individual is called a ''record,'' and the system, whether manual or computer based, is called a ''system of records.''

The Privacy Act requires agencies to publish a notice in the **Federal Register** and to prepare a report to the Administrator of the Office of Information and Regulatory Affairs, OMB whenever the agency publishes a new system of records or makes a significant change to an established system of records. Each agency is also required to send copies to the Chair of the Senate Committee on Homeland Security and Governmental Affairs and the Chair of the House Committee on Oversight and Government Reform. These reports are intended to permit an evaluation of the probable or potential effect of the proposal on the privacy rights of individuals.

This system collects records on individuals who are, were, or may be participants in any of the Student Financial Assistance Programs under title IV of the HEA, and who request assistance, directly or through a designated third party, from the Ombudsman. The Office of the Student Loan Ombudsman Records system collects the information for a number of purposes related to the duties and responsibilities of the Ombudsman, including: Verifying the identities of individuals; recording complaints and comments; tracking individual cases through final resolution; reporting trends; analyzing the data to recommend improvements in Student Financial Assistance Programs; and assisting in the resolution of disputes.

The Office of the Student Loan Ombudsman Records system consists of a variety of records that identify the individuals' complaints, requests for assistance, or other inquiries. Records include, but are not limited to: Written documentation of the individual's complaint, request for assistance, or other comment or inquiry; and information pertaining to the student's or parent's title IV Student Financial Assistance Program account(s), such as the person's name, SSN, date of birth, address, telephone number(s), and Federal Student Aid ID (FSA ID). Additionally, records include the name, address, and phone numbers of school(s), lender(s), secondary holder(s) or lender(s), guaranty agency(ies), servicer(s), and private collection agency(ies), if applicable.

On December 27, 1999, the Department published the first Privacy Act System of Record Notice (SORN) issuance for the Office of the Student Loan Ombudsman Records. This SORN has not been amended since this original date of publication. Given the amount of time that has passed, we have provided a summary of the changes and the corresponding rationale.

First, we altered the system location section because the Office of the Student Loan Ombudsman Records system will now be hosted by a cloud provider.

Second, we amended routine uses (1), (2), and (3). We modified routine use (1), Program Disclosure, to permit disclosures to be made for additional programmatic reasons to private collection agencies and Federal agencies in order to obtain further information about a complaint, request for assistance, or other inquiry before it can be resolved. Routine use (2), Disclosure for Use by Other Law Enforcement Agencies, and routine use (3), Enforcement Disclosure, were both modified to remove the limitation that disclosures could only be made for possible violations of criminal laws and

civil fraud and to permit disclosures to be made for other possible civil or administrative violations of the law.

Third, we added new routine uses (9), (10), and (11). Routine use (9), Borrower Complaint Disclosure, was added to accommodate sharing data regarding borrower complaints that were filed by borrowers with other agencies, such as the Consumer Financial Protection Bureau (CFPB). We added routine use (10), Freedom of Information Act (FOIA) and Privacy Act Advice Disclosure, so that we could make disclosures from this system to OMB and the Department of Justice (DOJ) to obtain advice on FOIA and Privacy Act requests for records in this system of records.

Lastly, we added routine use (11), Disclosure in the Course of Responding to a Breach of Data, to comply with OMB's guidance, in OMB Memorandum 07–16, which advised the Department to add this routine use to appropriate systems.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available via the Federal Digital System at: *www.gpo.gov/fdsys.* At this site you can view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access documents of the Department published in the **Federal Register** by using the article search feature at: *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Dated: March 2, 2016.

James W. Runcie,

Chief Operating Officer, Federal Student Aid.

For the reasons discussed in the preamble, the Chief Operating Officer of Federal Student Aid of the U.S. Department of Education (Department) publishes a notice of an altered system of records to read as follows:

SYSTEM NUMBER:

18–11–11

SYSTEM NAME:

Office of the Student Loan Ombudsman Records.

SECURITY CLASSIFICATION:

None.

SYSTEM LOCATION:

Salesforce Data Center, primary data center in 44521 Hastings Drive, Ashburn, VA 20147. The system is accessible via the Internet to different categories of users, including Department personnel, customers, and designated agents of the Department. As a result, these users may be at any location where they have Internet access.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

This system contains records on individuals who are, were, or may be participants in any of the Student Financial Assistance Programs under title IV of the Higher Education Act of 1965, as amended (HEA), and who request assistance, directly or through a designated third party, from the Ombudsman.

CATEGORIES OF RECORDS IN THE SYSTEM:

This system consists of a variety of records that identify the individuals' complaints, requests for assistance, or other inquiries. Records include, but are not limited to: Written documentation of the individual's complaint, request for assistance, or other comment or inquiry; and information pertaining to the student's or parent's title IV Student Financial Assistance Program account(s), such as the person's name, Social Security number (SSN), date of birth, address, telephone number(s), and Federal Student Aid ID (FSA ID). Additionally, records will include the name, address, and phone numbers of school(s), lender(s), secondary holder(s) or lender(s), guaranty agency(ies), servicer(s), and private collection agency(ies), if applicable.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Section 141(f) of the HEA (20 U.S.C. 1018(f)).

PURPOSE(S):

The information contained in this system will be used for a number of purposes related to the duties and responsibilities of the Ombudsman, including: Verifying the identities of individuals; recording complaints and comments; tracking individual cases through final resolution; reporting trends; analyzing the data to recommend improvements in Student Financial Assistance Programs; and assisting in the resolution of disputes.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

The Department may disclose information contained in a record in this system of records under the routine uses listed in this system of records without the consent of the individual if the disclosure is compatible with the purposes for which the record was collected. These disclosures may be made on a case-by-case basis or, if the Department has complied with the computer matching requirements of the Privacy Act of 1974, as amended (Privacy Act), under a computer matching agreement.

(1) *Program Disclosure.* The Department may disclose records to Federal agencies, State agencies, schools, lenders, guaranty agencies, servicers, and private collection agencies when it is necessary to obtain further information about the complaint, request for assistance, or other inquiry before it can be resolved.

(2) *Disclosure for Use by Other Law Enforcement Agencies.* The Department may disclose information to any Federal, State, local, or foreign agency or other public authority responsible for enforcing, investigating, or prosecuting violations of administrative, civil, or criminal law or regulation if that information is relevant to any enforcement, regulatory, investigative, or prosecutorial responsibility within the receiving entity's jurisdiction.

(3) *Enforcement Disclosure.* In the event that information in this system of records indicates, either on its face or in connection with other information, a violation or potential violation of any applicable statute, regulation, or order of a competent authority, the Department may disclose the relevant records to the appropriate agency, whether foreign, Federal, State, tribal, or local, charged with the responsibility of investigating or prosecuting that violation or charged with enforcing or implementing the statute, Executive order, rule, regulation, or order issued pursuant thereto.

(4) *Litigation and Alternative Dispute Resolution (ADR) Disclosures.*

(a) *Introduction.* In the event that one of the parties listed below is involved in litigation or ADR, or has an interest in such litigation or ADR, the Department may disclose certain records to the parties described in paragraphs (b), (c), and (d) of this routine use under the conditions specified in those paragraphs:

(i) The Department, or any component of the Department;

(ii) Any Department employee in his or her official capacity;

(iii) Any Department employee in his or her individual capacity if the Department of Justice (DOJ) has been requested to or has agreed to provide or arrange for representation for the employee;

(iv) Any Department employee in his or her individual capacity if the Department has agreed to represent the employee; or

(v) The United States if the Department determines that the litigation is likely to affect the Department or any of its components.

(b) *Disclosure to the DOJ.* If the Department determines that disclosure of certain records to the DOJ is relevant and necessary to litigation or ADR, the Department may disclose those records as a routine use to the DOJ.

(c) *Adjudicative Disclosures.* If the Department determines that it is relevant and necessary to the litigation or ADR to disclose certain records to an adjudicative body before which the Department is authorized to appear, to an individual, or to an entity designated by the Department or otherwise empowered to resolve or mediate disputes, the Department may disclose those records as a routine use to the adjudicative body, individual, or entity.

(d) *Disclosures to parties, counsels, representatives, and witnesses.* If the Department determines that disclosure of certain records to a party, counsel, representative, or witness is relevant and necessary to the litigation or ADR, the Department may disclose those records as a routine use to the party, counsel, representative, or witness.

(5) *Disclosure to the DOJ.* The Department may disclose records to the DOJ to the extent necessary for obtaining DOJ advice on any matter relevant to an audit, inspection, or other inquiry related to the programs covered by this system.

(6) *Contract Disclosure.* If the Department contracts with an entity for the purposes of performing any function that requires disclosure of records in this system to employees of the contractor, the Department may disclose the records to those employees. Before entering into such a contract, the Department shall require the contractor to maintain Privacy Act safeguards as required under 5 U.S.C. 552a(m) with respect to the records in the system.

(7) *Research Disclosure.* The Department may disclose records to a researcher if an appropriate official of the Department determines that the individual or organization to which the disclosure would be made is qualified to carry out specific research related to functions or purposes of this system of records. The official may disclose records from this system of records to that researcher solely for the purpose of carrying out that research related to the functions or purposes of this system of records. The researcher shall be required to maintain Privacy Act safeguards with respect to the disclosed records.

(8) *Congressional Member Disclosure.* The Department may disclose records to a member of Congress from the record of an individual in response to an inquiry from the member made at the written request of that individual. The member's right to the information is no greater than the right of the individual who requested it.

(9) *Borrower Complaint Disclosure.* If a record is relevant and necessary to a borrower complaint regarding participants in any Student Financial Assistance Programs under title IV of the HEA, the Department may disclose a record from this system of records in the course of investigating, fact-finding, or adjudicating the complaint to: Any party to the complaint; the party's counsel or representative; a witness; or a designated fact-finder, mediator, or other person designated to resolve issues or decide the matter. The disclosure may only be made during the course of the investigation, fact-finding, or adjudication.

(10) *Freedom of Information Act (FOIA) and Privacy Act Advice Disclosure.* The Department may disclose records from this system of records to the DOJ or Office of Management and Budget (OMB) if the Department concludes that disclosure is desirable or necessary in determining whether particular records are required to be disclosed under the FOIA or the Privacy Act.

(11) *Disclosure in the Course of Responding to a Breach of Data.* The Department may disclose records from this system of records to appropriate agencies, entities, and persons when: (a) The Department suspects or has confirmed that the security or confidentiality of information in this system has been compromised; (b) the Department has determined that as a result of the suspected or confirmed compromise, there is a risk of harm to economic or property interests, identity theft or fraud, or harm to the security or integrity of this system or other systems or programs (whether maintained by the Department or by another agency or entity) that rely upon the compromised information; and (c) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist the Department's efforts to respond to the suspected or confirmed compromise and prevent, minimize, or remedy such harm.

DISCLOSURE TO CONSUMER REPORTING AGENCIES:

Not applicable.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

These records will be maintained either in hard copy or in an electronic database.

RETRIEVABILITY:

Records are indexed by SSN, name, date of birth, and case tracking number.

SAFEGUARDS:

Access to and use of these records shall be limited to those persons whose official duties require access. This includes staff members of the Office of the Student Loan Ombudsman, other Department offices, and agents of the Department. All physical access to the site where this system of records is maintained is controlled and monitored by security personnel who check each individual entering the building for his or her employee or visitor badge.

The computer system offers a high degree of resistance to tampering and circumvention. This security system limits data access to staff on a ''need to know'' basis, and controls individual users' ability to access and alter records within the system. All users of this system of records are given unique user IDs with personal identifiers. All interactions by individual users with the system are recorded.

RETENTION AND DISPOSAL:

The records are retained for 10 years after cut off on close of case or final determination, and then destroyed in accordance with the Department's records retention and disposition schedule 052 FSA Ombudsman Case Files.

SYSTEM MANAGER(S) AND ADDRESS:

Ombudsman, Federal Student Aid, U.S. Department of Education, 830 First Street NE., Room 41I1, Washington, DC 20202.

NOTIFICATION PROCEDURE:

If you wish to determine whether a record exists regarding you in the system of records, contact the system manager. Your request must meet the requirements of the Department's Privacy Act regulations at 34 CFR 5b.5, including proof of identity.

RECORD ACCESS PROCEDURES:

If you wish to gain access to a record regarding you in the system of records, contact the system manager. Your request must meet the requirements of the Department's Privacy Act regulations at 34 CFR 5b.5, including proof of identity.

CONTESTING RECORD PROCEDURES:

If you wish to contest the content of a record regarding you in the system of records, contact the system manager. Your request must meet the requirements of the Department's Privacy Act regulations at 34 CFR 5b.7.

RECORD SOURCE CATEGORIES:

Information is obtained from the individuals (*e.g.,* borrowers), Federal agencies, State agencies, schools, lenders, private collection agencies, and guaranty agencies.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

[FR Doc. 2016–05015 Filed 3–7–16; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Applications for New Awards; Education Research and Special Education Research Grant Programs

AGENCY: Institute of Education Sciences, Department of Education.

ACTION: Notice.

SUMMARY:

Overview Information:

Education Research and Special Education Research Grant Programs.

Notice inviting applications for new awards for fiscal year (FY) 2017.

Catalog of Federal Domestic Assistance (CFDA) Numbers: 84.305A, 84.305B, 84.305D, 84.305H, 84.305L, 84.305N, 84.324A, 84.324B, and 84.324L.

The Deputy Director for Policy and Research, Delegated the Duties of the Director, of the Institute of Education Sciences (Institute) announces the Institute's FY 2017 competitions for grants to support education research and special education research. The Delegated Director takes this action under the Education Sciences Reform Act of 2002. The Institute's purpose in awarding these grants is to provide national leadership in expanding fundamental knowledge and understanding of (1) developmental and school readiness outcomes for infants and toddlers with or at risk for disability, and (2) education outcomes for all students from early childhood education through postsecondary and adult education.

DATES: The dates when applications are available and the deadlines for transmittal of applications invited under this notice are indicated in the chart at the end of this notice.

SUPPLEMENTARY INFORMATION:

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The central purpose of the Institute's research grant programs is to provide interested individuals and the general public with reliable and valid information about education practices that support learning and improve academic achievement and access to education opportunities for all students. These interested individuals include parents, educators, students, researchers, and policymakers. In carrying out its grant programs, the Institute provides support for programs of research in areas of demonstrated national need.

Competitions in This Notice: The Institute will conduct nine research competitions in FY 2017 through two of its centers:

The Institute's National Center for Education Research (NCER) will hold six competitions, one in each of the following areas:

- Education research;
- Education research training;
- Statistical and research methodology in education;
- Partnerships and collaborations focused on problems of practice or policy;
- Low-cost, short-duration evaluations; and
- Research networks.

The Institute's National Center for Special Education Research (NCSER) will hold three competitions, one in each of the following areas:

- Special education research;
- Special education research training; and
- Low-cost, short-duration evaluations.

NCER Competitions

The Education Research Competition. Under this competition, NCER will consider only applications that address one of the following twelve education research topics:

- Cognition and Student Learning.
- Early Learning Programs and Policies.
- Education Leadership.
- Education Technology.
- Effective Teachers and Effective Teaching.
- English Learners.
- Improving Education Systems.
- Mathematics and Science Education.
- Postsecondary and Adult Education.
- Reading and Writing.
- Social and Behavioral Context for Academic Learning.
- Special Topics, which include
  - Arts in Education.
  - Career and Technical Education.
  - Systemic Approaches to Educating Highly Mobile Students.

The Research Training Programs in the Education Sciences Competition. Under this competition, NCER will consider only applications that address one of the following three topics:

- Pathways to the Education Sciences Research Training.
- Postdoctoral Research Training.
- Methods Training for Education Researchers.

The Statistical and Research Methodology in Education Competition. Under this competition, NCER will consider only applications that address one of the following two topics:

- Statistical and Research Methodology Grants.
- Early Career Statistical and Research Methodology Grants.

The Partnerships and Collaborations Focused on Problems of Practice or Policy Competition. Under this competition, NCER will consider only applications that address one of the following two topics:

- Researcher-Practitioner Partnerships in Education Research.
- Evaluation of State and Local Education Programs and Policies.

The Low-Cost, Short-Duration Evaluation of Education Interventions Competition. Under this competition, NCER will consider only applications that address low-cost, short-duration evaluation of education interventions.

The Research Networks Focused on Critical Problems of Education Policy and Practice Competition. Under this competition, NCER will consider only applications that address one of the following two topics:

- Exploring Science Teaching in Elementary School Classrooms, which includes
  - Network Lead.
  - Research Team.
- Scalable Strategies to Support College Completion, which includes
  - Network Lead.
  - Research Team.

NCSER Competitions

The Special Education Research Competition. In FY 2017, NCSER will consider only applications that focus on teachers and other instructional personnel within one of the following eleven topics:

- Autism Spectrum Disorders.
- Cognition and Student Learning in Special Education.
- Early Intervention and Early Learning in Special Education.
- Families of Children with Disabilities.
- Mathematics and Science Education.

- Professional Development for Teachers and Other Instructional Personnel.
- Reading, Writing, and Language Development.
- Social and Behavioral Outcomes to Support Learning.
- Special Education Policy, Finance, and Systems.
- Technology for Special Education.
- Transition Outcomes for Secondary Students with Disabilities.

The Research Training Programs in Special Education Competition. Under this competition, NCSER will consider only applications that address early career development and mentoring in special education research.

The Low-Cost, Short-Duration Evaluation of Special Education Interventions Competition. Under this competition, NCSER will consider only applications that address low-cost, short-duration evaluation of special education interventions.

Program Authority: 20 U.S.C. 9501 *et seq.*

Applicable Regulations: (a) The Education Department General Administrative Regulations in 34 CFR parts 77, 81, 82, 84, 86, 97, 98, and 99. In addition, the regulations in 34 CFR part 75 are applicable, except for the provisions in 34 CFR 75.100, 75.101(b), 75.102, 75.103, 75.105, 75.109(a), 75.200, 75.201, 75.209, 75.210, 75.211, 75.217(a)-(c), 75.219, 75.220, 75.221, 75.222, and 75.230. (b) The Office of Management and Budget Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement) in 2 CFR part 180, as adopted and amended as regulations of the Department in 2 CFR part 3485. (c) The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards in 2 CFR part 200, as adopted and amended in 2 CFR part 3474.

Note: The regulations in 34 CFR part 86 apply to institutions of higher education only.

II. Award Information

Types of Awards: Discretionary grants and cooperative agreements.

Fiscal Information: Although Congress has not yet enacted an appropriation for fiscal year 2017, the Institute is inviting applications for these competitions now so that applicants can have adequate time to prepare their applications. The Department may announce additional topics later in 2016. The actual award of grants will depend on the availability of funds.

Estimated Range of Awards: See chart at the end of this notice.

Estimated Size and Number of Awards: The size of the awards will depend on the scope of the projects proposed. The number of awards made under each competition will depend on the quality of the applications received for that competition, the availability of funds, and the following limits on awards for specific competitions and topics set by the Institute. See the chart at the end of this notice for additional information.

The Institute may waive any of the following limits on awards for a specific competition or topic in the special case that the peer review process results in a tie between two or more grant applications, making it impossible to adhere to the limits without funding only some of the equally ranked applications. In that case, the Institute may make a larger number of awards to include all applications of the same rank.

For the NCER's Research Training Programs in the Education Sciences competition, we will award no more than four grants under the Pathways to the Education Sciences Research Training topic.

For NCER's Research Networks Focused on Critical Problems of Education Policy and Practice competition, we will award no more than five grants under the Exploring Science Teaching in Elementary School Classrooms topic (one grant under the Network Lead and four grants under the Research Team) and four grants under the Scalable Strategies to Support College Completion topic (one grant under the Network Lead and three grants under the Research Team).

For NCSER's Research Training Programs in Special Education competition, we will award no more than five grants under the Early Career Development and Mentoring topic.

For NCSER's Low-Cost, Short-Duration Evaluation of Special Education Interventions, we will award no more than four grants.

The Institute may change the maximum number of awards per competition through a notice in the **Federal Register**. Contingent on the availability of funds and the quality of applications, we may make additional awards in FY 2018 from the list of unfunded applications from the FY 2017 competitions.

Note: The Department is not bound by any estimates in this notice.

Project Period: See chart at the end of this notice.

III. Eligibility Information

1. *Eligible Applicants:* Applicants that have the ability and capacity to conduct scientifically valid research are eligible to apply. Eligible applicants include, but are not limited to, nonprofit and for-profit organizations and public and private agencies and institutions of higher education, such as colleges and universities.

2. *Cost Sharing or Matching:* These programs do not require cost sharing or matching.

IV. Application and Submission Information

1. *Request for Applications and Other Information:* Information regarding program and application requirements for the competitions will be contained in the NCER and NCSER Requests for Applications (RFAs), which will be available on the Institute's Web site at: *http://ies.ed.gov/funding/.* Each competition will have its own application package. The RFAs for all nine competitions announced in this notice will be available at the Web site listed above on or before March 31, 2016. The dates on which the application packages for these competitions will be available are indicated in the chart at the end of this notice.

The selection criteria and review procedures for the competitions are contained in the RFAs. The RFAs also include information on the maximum award available under each grant competition. Applications that include proposed budgets higher than the relevant maximum award will not be considered for an award. The Institute may change the maximum amount through a notice in the **Federal Register**.

Individuals with disabilities can obtain a copy of the application package in an accessible format (*e.g.,* Braille, large print, audiotape, or compact disc) by contacting the person or team listed under Accessible Format in section VIII of this notice.

2. *Content and Form of Application Submission:* Requirements concerning the content of an application are contained in the RFA for the specific competition. The forms that must be submitted are in the application package for the specific competition.

3. *Submission Dates and Times:* The deadline date for transmittal of applications invited under this notice is indicated in the chart at the end of this notice and in the RFAs for the competitions.

We do not consider an application that does not comply with the deadline requirements.

Application packages for grants under these competitions must be obtained from and submitted electronically using the Grants.gov Apply site (*www.Grants.gov*). For information (including dates and times) about how to submit your application package electronically, or in paper format by mail or hand delivery if you qualify for an exception to the electronic submission requirement, please refer to Other Submission Requirements in section IV of this notice.

Other Submission Requirements of this notice.

Individuals with disabilities who need an accommodation or auxiliary aid in connection with the application process should contact the person listed under **FOR FURTHER INFORMATION CONTACT** in section VII of this notice and the chart at the end of this notice. If the Department provides an accommodation or auxiliary aid to an individual with a disability in connection with the application process, the individual's application remains subject to all other requirements and limitations in this notice.

4. *Intergovernmental Review:* This competition is not subject to Executive Order 12372 and the regulations in CFR part 79.

5. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice.

6. *Data Universal Numbering System Number, Taxpayer Identification Number, and System for Award Management:* To do business with the Department of Education, you must—

a. Have a Data Universal Numbering System (DUNS) number and a Taxpayer Identification Number (TIN);

b. Register both your DUNS number and TIN with the System for Award Management (SAM) (formerly the Central Contractor Registry), the Government's primary registrant database;

c. Provide your DUNS number and TIN on your application; and

d. Maintain an active SAM registration with current information while your application is under review by the Department and, if you are awarded a grant, during the project period.

You can obtain a DUNS number from Dun and Bradstreet at the following Web site: *http://fedgov.dnb.com/webform.* A DUNS number can be created within one to two business days.

If you are a corporate entity, agency, institution, or organization, you can obtain a TIN from the Internal Revenue Service. If you are an individual, you can obtain a TIN from the Internal Revenue Service or the Social Security Administration. If you need a new TIN, please allow two to five weeks for your TIN to become active.

The SAM registration process can take approximately seven business days, but may take upwards of several weeks, depending on the completeness and accuracy of the data you enter into the SAM database. Thus, if you think you might want to apply for Federal financial assistance under a program administered by the Department, please allow sufficient time to obtain and register your DUNS number and TIN. We strongly recommend that you register early.

Note: Once your SAM registration is active, you will need to allow 24 to 48 hours before you can access the information in, and submit an application through, Grants.gov.

If you are currently registered with SAM, you may not need to make any changes. However, please make certain that the TIN associated with your DUNS number is correct. Also, note that you will need to update your registration annually. This may take three or more business days.

Information about SAM is available at *www.SAM.gov.* To further assist you with obtaining and registering your DUNS number and TIN in SAM or updating your existing SAM account, we have prepared a SAM.gov Tip Sheet, which you can find at: *www2.ed.gov/fund/grant/apply/sam-faqs.html.*

In addition, if you are submitting your application via Grants.gov, you must (1) be designated by your organization as an Authorized Organization Representative (AOR); and (2) register yourself with Grants.gov as an AOR. Details on these steps are outlined at the following Grants.gov Web page: *www.grants.gov/web/grants/register.html.*

7. *Other Submission Requirements:* Applications for grants under these competitions must be submitted electronically unless you qualify for an exception to this requirement in accordance with the instructions in this section.

a. *Electronic Submission of Applications.*

Applications for grants under the Education Research, Research Training Programs in the Education Sciences, Statistical and Research Methodology in Education, Partnerships and Collaborations Focused on Problems of Practice or Policy, Low-Cost, Short-Duration Evaluation of Education Interventions, Research Networks Focused on Critical Problems of Education Policy and Practice, Special Education Research, Research Training Programs in Special Education, and Low-Cost, Short-Duration Evaluation of Special Education Interventions competitions, CFDA numbers 84.305A, 84.305B, 84.305D, 84.305H, 84.305L, 84.305N, 84.324A, 84.324B, and 84.324L must be submitted electronically using the Governmentwide Grants.gov Apply site at *www.Grants.gov.* Through this site, you will be able to download a copy of the application package, complete it offline, and then upload and submit your application. You may not email an electronic copy of a grant application to us.

We will reject your application if you submit it in paper format unless, as described elsewhere in this section, you qualify for one of the exceptions to the electronic submission requirement *and* submit, no later than two weeks before the application deadline date, a written statement to the Department that you qualify for one of these exceptions. Further information regarding calculation of the date that is two weeks before the application deadline date is provided later in this section under *Exception to Electronic Submission Requirement.*

You may access the electronic grant applications for the Education Research, Research Training Programs in the Education Sciences, Statistical and Research Methodology in Education, Partnerships and Collaborations Focused on Problems of Practice or Policy, Low-Cost, Short-Duration Evaluation of Education Interventions, Research Networks Focused on Critical Problems of Education Policy and Practice, Special Education Research, Research Training Programs in Special Education, and Low-Cost, Short-Duration Evaluation of Special Education Interventions competitions at *www.Grants.gov.* You must search for the downloadable application package for each competition by the CFDA number. Do not include the CFDA number's alpha suffix in your search (*e.g.,* search for 84.305, not 84.305A).

Please note the following:

- When you enter the Grants.gov site, you will find information about submitting an application electronically through the site, as well as the hours of operation.
- Applications received by Grants.gov are date and time stamped. Your application must be fully uploaded and submitted and must be date and time stamped by the Grants.gov system no later than 4:30:00 p.m., Washington, DC time, on the application deadline date. Except as otherwise noted in this section, we will not accept your application if it is received—that is, date and time stamped by the Grants.gov

system—after 4:30:00 p.m., Washington, DC time, on the application deadline date. We do not consider an application that does not comply with the deadline requirements. When we retrieve your application from Grants.gov, we will notify you if we are rejecting your application because it was date and time stamped by the Grants.gov system after 4:30:00 p.m., Washington, DC time, on the application deadline date.

- The amount of time it can take to upload an application will vary depending on a variety of factors, including the size of the application and the speed of your Internet connection. Therefore, we strongly recommend that you do not wait until the application deadline date to begin the submission process through Grants.gov.
- You should review and follow the Education Submission Procedures for submitting an application through Grants.gov that are included in the application package for the competition to ensure that you submit your application in a timely manner to the Grants.gov system. You can also find the Education Submission Procedures pertaining to Grants.gov under News and Events on the Department's G5 system home page at *www.G5.gov.* In addition, for specific guidance and procedures for submitting an application through Grants.gov, please refer to the Grants.gov Web site at: *www.grants.gov/web/grants/applicants/apply-for-grants.html.*
- You will not receive additional point value because you submit your application in electronic format, nor will we penalize you if you qualify for an exception to the electronic submission requirement, as described elsewhere in this section, and submit your application in paper format.
- You must submit all documents electronically, including all information you typically provide on the following forms: the Application for Federal Assistance (SF 424), the Department of Education Supplemental Information for SF 424, Budget Information—Non-Construction Programs (ED 524), and all necessary assurances and certifications.
- You must upload any narrative sections and all other attachments to your application as files in a read-only non-modifiable Portable Document Format (PDF). Do not upload an interactive or fillable PDF file. If you upload a file type other than a read-only, non-modifiable PDF (*e.g.,* Word, Excel, WordPerfect, etc.) or submit a password-protected file, we will not review that material. Please note that this could result in your application not being considered for funding because the material in question—for example, the project narrative—is critical to a meaningful review of your proposal. For that reason it is important to allow yourself adequate time to upload all material as PDF files. The Department will not convert material from other formats to PDF.
- Your electronic application must comply with any page-limit requirements described in the relevant RFA for your application.
- After you electronically submit your application, you will receive from Grants.gov an automatic notification of receipt that contains a Grants.gov tracking number. (This notification indicates receipt by Grants.gov only, not receipt by the Department.) Grants.gov will also notify you automatically by email if your application met all the Grants.gov validation requirements or if there were any errors (such as submission of your application by someone other than a registered Authorized Organization Representative, or inclusion of an attachment with a file name that contains special characters). You will be given an opportunity to correct any errors and resubmit, but you must still meet the deadline for submission of applications.

Once your application is successfully validated by Grants.gov, the Department will retrieve your application from Grants.gov and send you an email with a unique PR/Award number for your application.

These emails do not mean that your application is without any disqualifying errors. While your application may have been successfully validated by Grants.gov, it must also meet the Department's application requirements as specified in this notice and in the application instructions. Disqualifying errors could include, for instance, failure to upload attachments in a read-only, non-modifiable PDF; failure to submit a required part of the application; or failure to meet applicant eligibility requirements. It is your responsibility to ensure that your submitted application has met all of the Department's requirements.

- We may request that you provide us original signatures on forms at a later date.

Application Deadline Date Extension in Case of Technical Issues with the Grants.gov System: If you are experiencing problems submitting your application through Grants.gov, please contact the Grants.gov Support Desk, toll free, at 1–800–518–4726. You must obtain a Grants.gov Support Desk Case Number and must keep a record of it.

If you are prevented from electronically submitting your application on the application deadline date because of technical problems with the Grants.gov system, we will grant you an extension until 4:30:00 p.m., Washington, DC time, the following business day to enable you to transmit your application electronically or by hand delivery. You also may mail your application by following the mailing instructions described elsewhere in this notice.

If you submit an application after 4:30:00 p.m., Washington, DC time, on the application deadline date, please contact the person listed under **FOR FURTHER INFORMATION CONTACT** in section VII of this notice and provide an explanation of the technical problem you experienced with Grants.gov, along with the Grants.gov Support Desk Case Number. We will accept your application if we can confirm that a technical problem occurred with the Grants.gov system and that that problem affected your ability to submit your application by 4:30:00 p.m., Washington, DC time, on the application deadline date. The Department will contact you after a determination is made on whether your application will be accepted.

Note: The extensions to which we refer in this section apply only to the unavailability of, or technical problems with, the Grants.gov system. We will not grant you an extension if you failed to fully register to submit your application to Grants.gov before the application deadline date and time or if the technical problem you experienced is unrelated to the Grants.gov system.

Exception to Electronic Submission Requirement: You qualify for an exception to the electronic submission requirement, and may submit your application in paper format, if you are unable to submit an application through the Grants.gov system because—

- You do not have access to the Internet; or
- You do not have the capacity to upload large documents to the Grants.gov system; and
- No later than two weeks before the application deadline date (14 calendar days or, if the fourteenth calendar day before the application deadline date falls on a Federal holiday, the next business day following the Federal holiday), you mail or fax a written statement to the Department, explaining which of the two grounds for an exception prevents you from using the Internet to submit your application.

If you mail your written statement to the Department, it must be postmarked no later than two weeks before the application deadline date. If you fax your written statement to the Department, we must receive the faxed

statement no later than two weeks before the application deadline date.

Address and mail statement to: Ellie Pelaez, U.S. Department of Education, 550 12th Street SW., Potomac Center Plaza, Room 4107, Washington, DC 20202.

Your paper application must be submitted in accordance with the mail or hand delivery instructions described in this notice.

b. *Submission of Paper Applications by Mail.*

If you qualify for an exception to the electronic submission requirement, you may mail (through the U.S. Postal Service or a commercial carrier) your application to the Department. You must mail the original and two copies of your application, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number: *[Identify the CFDA number, including suffix letter, for the competition under which you are applying.]*), LBJ Basement Level 1, 400 Maryland Avenue SW., Washington, DC 20202–4260.

You must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark.

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service.

(3) A dated shipping label, invoice, or receipt from a commercial carrier.

(4) Any other proof of mailing acceptable to the Secretary of the U.S. Department of Education.

If you mail your application through the U.S. Postal Service, we do not accept either of the following as proof of mailing:

(1) A private metered postmark.

(2) A mail receipt that is not dated by the U.S. Postal Service.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, you should check with your local post office.

We will not consider applications postmarked after the application deadline date.

c. *Submission of Paper Applications by Hand Delivery.*

If you qualify for an exception to the electronic submission requirement, you (or a courier service) may deliver your paper application to the Department by hand. You must deliver the original and two copies of your application by hand, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number: *[Identify the CFDA number, including suffix letter, for the competition under which you are applying.]*) 550 12th Street SW., Room 7039, Potomac Center Plaza, Washington, DC 20202–4260.

The Application Control Center accepts hand deliveries daily between 8:00 a.m. and 4:30:00 p.m., Washington, DC time, except Saturdays, Sundays, and Federal holidays.

Note for Mail or Hand Delivery of Paper Applications: If you mail or hand deliver your application to the Department—

(1) You must indicate on the envelope and—if not provided by the Department—in Item 11 of the SF 424 the CFDA number, including suffix letter, if any, of the competition under which you are submitting your application; and

(2) The Application Control Center will mail to you a notification of receipt of your grant application. If you do not receive this notification within 15 business days from the application deadline date, you should call the U.S. Department of Education Application Control Center at (202) 245–6288.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for these competitions are provided in the RFAs.

2. *Review and Selection Process:* We remind potential applicants that in reviewing applications in any discretionary grant competition, the Secretary may consider, under 34 CFR 75.217(d)(3), the past performance of the applicant in carrying out a previous award, such as the applicant's use of funds, achievement of project objectives, and compliance with grant conditions. The Secretary may also consider whether the applicant failed to submit a timely performance report or submitted a report of unacceptable quality.

In addition, in making a competitive grant award, the Secretary also requires various assurances including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department of Education (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

3. *Special Conditions:* Under 2 CFR 3474.10, the Secretary may impose special conditions and, in appropriate circumstances, high-risk conditions on a grant in regards to key aspects of the proposed research design and if the applicant or grantee is not financially stable; has a history of unsatisfactory performance; has a financial or other management system that does not meet the standards in 2 CFR part 200, subpart D; has not fulfilled the conditions of a prior grant; or is otherwise not responsible.

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN); or we may send you an email containing a link to access an electronic version of your GAN. We may notify you informally, also.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Grant Administration:* Applicants should budget for an annual two-day meeting for project directors to be held in Washington, DC.

4. *Reporting:* (a) If you apply for a grant under one of the competitions announced in this notice, you must ensure that you have in place the necessary processes and systems to comply with the reporting requirements in 2 CFR part 170 should you receive funding under the competition. This does not apply if you have an exception under 2 CFR 170.110(b).

(b) At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multi-year award, you must submit an annual performance report that provides the most current performance and financial expenditure information as directed by the Secretary under 34 CFR 75.118. The Secretary may also require more frequent performance reports under 34 CFR 75.720(c). For specific requirements on reporting, please go to *www.ed.gov/fund/grant/apply/appforms/appforms.html.*

5. *Performance Measures:* To evaluate the overall success of its education research and special education research grant programs, the Institute annually assesses the percentage of projects that result in peer-reviewed publications, the number of newly developed or modified interventions with evidence of promise for improving student education outcomes, and the number of Institute-

supported interventions with evidence of efficacy in improving student outcomes including school readiness outcomes for young children and student academic outcomes and social and behavioral competencies for school-age students. School readiness outcomes include pre-reading, reading, pre-writing, early mathematics, early science, and social-emotional skills that prepare young children for school. Student academic outcomes include learning and achievement in core academic content areas (reading, writing, math, and science) and outcomes that reflect students' successful progression through the education system (*e.g.,* course and grade completion; high school graduation; postsecondary enrollment, progress, and completion). Social and behavioral competencies include social and emotional skills, attitudes, and behaviors that may be important to student's academic and post-academic success. Additional education outcomes for students with or at risk of disability include developmental outcomes for infants and toddlers (birth to age three) with or at risk for a disability pertaining to cognitive, communicative, linguistic, social, emotional, adaptive, functional, or physical development; and developmental and functional outcomes that improve education outcomes, transition to employment, independent living, and postsecondary education for students with disabilities.

6. *Continuation Awards:* In making a continuation award under 34 CFR 75.253, the Secretary considers, among other things: whether a grantee has made substantial progress in meeting the goals and objectives of the project; whether the grantee has expended funds in a manner that is consistent with its approved application and budget; and, if the Secretary has established performance measurement requirements, whether the grantee has met the performance targets in the grantee's approved application.

In making a continuation award, the Secretary also considers whether the grantee is operating in compliance with the assurances in its approved application, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

VII. Agency Contact

FOR FURTHER INFORMATION CONTACT: The contact person associated with a particular research competition is listed in the chart at the end of this notice, in the relevant RFA, and in the relevant application package. The date on which applications will be available, the deadline for transmittal of applications, the estimated range of awards, and the project period ranges are also listed in the chart and in the RFAs that are posted at the following Web sites: *http://ies.ed.gov/funding/* and *www.ed.gov/about/offices/list/ies/programs.html.*

If you use a telecommunications device for the deaf (TDD) or a text telephone (TTY), call the Federal Relay Service, toll free, at 1–800–877–8339.

VIII. Other Information

Accessible Format: Individuals with disabilities can obtain this document and a copy of the RFA in an accessible format (*e.g.,* braille, large print, audiotape, or compact disc) on request to the appropriate program contact person listed in the chart at the end of this notice.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available via the Federal Digital System at: *www.gpo.gov/fdsys.* At this site you can view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Adobe Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at this site.

You may also access documents of the Department published in the **Federal Register** by using the article search feature at: *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Dated: March 3, 2016.

Ruth Neild,

Deputy Director for Policy and Research, Delegated Duties of the Director, Institute of Education Sciences.

CFDA No. and name	Application package available	Deadline for transmittal of applications	Estimated range of awards*	Project period	FOR FURTHER INFORMATION CONTACT
National Center for Education Research (NCER)					
84.305A Education Research: ■ Cognition and Student Learning. ■ Early Learning Programs and Policies. ■ Education Leadership. ■ Education Technology. ■ Effective Teachers and Effective Teaching. ■ English Learners. ■ Improving Education Systems. ■ Mathematics and Science Education. ■ Postsecondary and Adult Education. ■ Reading and Writing. ■ Social and Behavioral Context for Academic Learning. ■ Special Topics. ○ Arts in Education. ○ Career and Technical Education. ○ Systemic Approaches to Educating Highly Mobile Students.	May 5, 2016	August 4, 2016	$100,000 to $760,000	Up to 5 years	Rebecca McGill-Wilkinson, *Rebecca.McGill@ed.gov.*
84.305B Research Training Programs in the Education Sciences:	May 19, 2016	August 4, 2016	$50,000 to $270,000	Up to 5 years	Meredith Larson, *Meredith.Larson@ed.gov.*

CFDA No. and name	Application package available	Deadline for transmittal of applications	Estimated range of awards*	Project period	FOR FURTHER INFORMATION CONTACT
■ Pathways to the Education Sciences Research Training.. ■ Postdoctoral Research Training Program. ■ Methods Training for Education Researchers.					
84.305D Statistical and Research Methodology in Education: ■ Statistical and Research Methodology Grants.. ■ Early Career Statistical and Research Methodology Grants.	May 5, 2016	August 4, 2016	$40,000 to $300,000	Up to 3 years	Phill Gagne, *Phill.Gagne@ed.gov*.
84.305H Partnerships and Collaborations Focused on Problems of Practice or Policy: ■Researcher-Practitioner Partnerships in Education Research.. ■ Evaluation of State and Local Education Programs and Policies.	May 19, 2016	August 4, 2016	$50,000 to $1,000.000 ...	Up to 5 years	Allen Ruby, *Allen.Ruby@ed.gov*.
84.305L Low-Cost, Short-Duration Evaluation of Education Interventions.	May 19, 2016	August 4, 2016	$50,000–$125,000	Up to 2 Years	Allen Ruby, *Allen.Ruby@ed.gov*.
84.305N Research Networks Focused on Critical Problems of Education Policy and Practice: ■ Exploring Science Teaching in Elementary School Classrooms. ■ Scalable Strategies to Support College Completion	May 19, 2016	August 4, 2016	$500,000 to $800,000	Up to 5 years	Wai-Ying Chow (Science Teaching), *Wai-Ying.Chow@ed.gov* James.Benson (College Completion), *James.Benson@ed.gov*.
National Center for Special Education Research (NCSER)					
84.324A Special Education Research: In FY 2017,the focus of 84.324A is on teachers and other instructional personnel within each of the following topics:. ■ Autism Spectrum Disorders ..... ■ Cognition and Student Learning in Special Education. ■ Early Intervention and Early Learning in Special Education. ■ Families of Children with Disabilities. ■ Mathematics and Science Education. ■ Professional Development for Teachers and Other Instructional Personnel. ■ Reading, Writing, and Language Development. ■ Social and Behavioral Outcomes to Support Learning. ■ Special Education Policy, Finance, and Systems. ■ Technology for Special Education. ■ Transition Outcomes for Secondary Students with Disabilities.	May 5, 2016	August 4, 2016	$100,000 to $760,000	Up to 5 years	Jacquelyn Buckley, *Jacquelyn.Buckley@ed.gov*.
84.324B Research Training Programs in Special Education: ■ Early Career Development and Mentoring in Special Education Research.	May 19, 2016	August 4, 2016	$50,000 to $100,000	Up to 4 years	Katherine Taylor, *Katherine.Taylor@ed.gov*.
84.324L Low-Cost, Short-Duration Evaluation of Special Education Interventions.	May 19, 2016	August 4, 2016	$50,000 to $125,000	Up to 2 Years	Kimberley Sprague, *Kimberley.Sprague@ed.gov*.

*These estimates are annual amounts.

Note: The Department is not bound by any estimates in this notice.

Note: If you use a telecommunications device for the deaf (TDD) or a text telephone (TTY), call the Federal Relay Service, toll free, at 1–800–877–8339.

[FR Doc. 2016–05155 Filed 3–7–16; 8:45 am]
BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP15–518–000]

Freeport LNG Development, L.P., FLNG Liquefaction, LLC, FLNG Liquefaction 2, LLC, FLNG Liquefaction 3, LLC; Notice of Schedule for Environmental Review of the Freeport LNG Capacity Uprate Project

On June 15, 2015, Freeport LNG Development, L.P., FLNG Liquefaction, LLC, FLNG Liquefaction 2, LLC, and FLNG Liquefaction 3, LLC (collectively referred to as Freeport LNG) filed an application pursuant to Section 3(a) of the Natural Gas Act to amend the existing authorization for the Liquefaction Project, located in Brazoria County near Freeport, Texas. The proposed project is known as the Capacity Uprate Project (Project), and would allow for the liquefaction and export of an additional 0.34 billion cubic feet per day (bcf/d) equivalent of liquefied natural gas.

On June 24, 2015, the Federal Energy Regulatory Commission (Commission or FERC) issued its Notice of Application for the Project. Among other things, that notice alerted agencies issuing federal authorizations of the requirement to complete all necessary reviews and to reach a final decision on a request for a federal authorization within 90 days of the date of issuance of the Commission staff's Environmental Assessment (EA) for the Project. This instant notice identifies the FERC staff's planned schedule for the completion of the EA for the Project.

Schedule for Environmental Review

Issuance of EA March 31, 2016
90-day Federal Authorization Decision Deadline June 29, 2016

If a schedule change becomes necessary, additional notice will be provided so that the relevant agencies are kept informed of the Project's progress.

Project Description

Freeport LNG is seeking approval of an increase in the LNG production capacity of the previously approved Liquefaction Project from 1.8 bcf/d to about 2.14 Bcf/d. This is the estimated maximum LNG production capacity of the Liquefaction Project available for export under optimal operating conditions. The currently authorized liquefaction capacity for the Liquefaction Project was determined by Freeport LNG during the early stages engineering design. This amendment identifies and requests that the maximum quantity of LNG that could be produced in a particular year under well-developed engineering design parameters and specific operating conditions be used as the approved volumes.

Background

Freeport LNG identified no additional facilities or modification that would be necessary to enable the uprate. We received a request to intervene from the Sierra Club that included some environmental comments.

Additional Information

In order to receive notification of the issuance of the EA and to keep track of all formal issuances and submittals in specific dockets, the Commission offers a free service called eSubscription. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *www.ferc.gov/docs-filing/esubscription.asp.*

Additional information about the Project is available from the Commission's Office of External Affairs at (866) 208–FERC or on the FERC Web site (*www.ferc.gov*). Using the ''eLibrary'' link, select ''General Search'' from the eLibrary menu, enter the selected date range and ''Docket Number'' excluding the last three digits (*i.e.,* CP15–518), and follow the instructions. For assistance with access to eLibrary, the helpline can be reached at (866) 208–3676, TTY (202) 502–8659, or at *FERCOnlineSupport@ferc.gov.* The eLibrary link on the FERC Web site also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rule makings.

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05098 Filed 3–7–16; 8:45 am]
BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 308–000]

PacifiCorp Energy; Notice of Authorization for Continued Project Operation

On February 28, 2014, PacifiCorp Energy, licensee for the Wallowa Falls Hydroelectric Project, filed an Application for a New License pursuant to the Federal Power Act (FPA) and the Commission's regulations thereunder. The Wallowa Falls Hydroelectric Project is located on the East and West Forks of the Wallowa River and Royal Purple Creek in Wallowa County, Oregon.

The license for Project No. 308 was issued for a period ending February 28, 2016. Section 15(a)(1) of the FPA, 16 U.S.C. 808(a)(1), requires the Commission, at the expiration of a license term, to issue from year-to-year an annual license to the then licensee under the terms and conditions of the prior license until a new license is issued, or the project is otherwise disposed of as provided in section 15 or any other applicable section of the FPA. If the project's prior license waived the applicability of section 15 of the FPA, then, based on section 9(b) of the Administrative Procedure Act, 5 U.S.C. 558(c), and as set forth at 18 CFR 16.21(a), if the licensee of such project has filed an application for a subsequent license, the licensee may continue to operate the project in accordance with the terms and conditions of the license after the minor or minor part license expires, until the Commission acts on its application. If the licensee of such a project has not filed an application for a subsequent license, then it may be required, pursuant to 18 CFR 16.21(b), to continue project operations until the Commission issues someone else a license for the project or otherwise orders disposition of the project.

If the project is subject to section 15 of the FPA, notice is hereby given that an annual license for Project No. 308 is issued to the licensee for a period effective March 1, 2016 through February 28, 2017 or until the issuance of a new license for the project or other disposition under the FPA, whichever comes first. If issuance of a new license (or other disposition) does not take place on or before February 28, 2017, notice is hereby given that, pursuant to 18 CFR 16.18(c), an annual license under section 15(a)(1) of the FPA is renewed automatically without further order or notice by the Commission,

unless the Commission orders otherwise.

If the project is not subject to section 15 of the FPA, notice is hereby given that the licensee, PacifiCorp Energy, is authorized to continue operation of the Wallowa Falls Hydroelectric Project, until such time as the Commission acts on its application for a subsequent license.

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05099 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 6795–019]

Town of Pownal; Notice of Application Accepted for Filing, Soliciting Comments, Motions To Intervene, and Protests

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Type of Application:* Amendment of Exemption.

b. *Project No:* 6795–019.

c. *Date Filed:* February 3, 2016, as supplemented February 16, 2016.

d. *Applicant:* Town of Pownal.

e. *Name of Project:* Pownal Hydroelectric Project.

f. *Location:* The project is located on the Hoosic River, in Bennington County, Vermont.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. 791a–825r.

h. *Applicant Contact:* William F. Scully, Operating Manager, Hoosic River Hydro, LLC, P.O. Box 338 North Bennington, VT 05257 (802) 379–2469.

i. *FERC Contact:* B. Peter Yarrington, (202) 502–6129 or *peter.yarrington@ferc.gov.*

j. Deadline for filing comments, motions to intervene, and protests is 15 days from the issuance date of this notice by the Commission. The Commission strongly encourages electronic filing. Please file motions to intervene, protests, or comments using the Commission's eFiling system at *http://www.ferc.gov/docs-filing/efiling.asp.* Commenters can submit brief comments up to 6,000 characters, without prior registration, using the eComment system at *http://www.ferc.gov/docs-filing/ecomment.asp.* You must include your name and contact information at the end of your comments. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov,* (866) 208–3676 (toll free), or (202) 502–8659 (TTY). In lieu of electronic filing, please send a paper copy to: Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. Please include the project number (P–6795–019) on any comments, motions to intervene, or protests filed.

k. Description of Request: The applicant proposes to replace the project's existing, non-operable horizontal-double-runner turbine with a double-regulated Kaplan unit. The existing unit has a rated generating capacity of 400 kilowatts (kW) and a maximum hydraulic capacity of 355 cubic feet per second (cfs). The new unit would have a rated generating capacity of 500 kW and would operate with flows ranging from approximately 100 cfs to 332 cfs.

l. Locations of the Application: A copy of the application is available for inspection and reproduction at the Commission's Public Reference Room, located at 888 First Street, NE., Room 2A, Washington, DC 20426, or by calling (202) 502–8371. This filing may also be viewed on the Commission's Web site at *http://www.ferc.gov/docs-filing/elibrary.asp.* Enter the docket number excluding the last three digits in the docket number field to access the document. You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via email of new filings and issuances related to this or other pending projects. For assistance, call 1 (866) 208- 3676 or email *FERCOnlineSupport@ferc.gov,* for TTY, call (202) 502–8659. A copy is also available for inspection and reproduction at the address in item (h) above.

m. Individuals desiring to be included on the Commission's mailing list should so indicate by writing to the Secretary of the Commission.

n. Comments, Protests, or Motions to Intervene: Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

o. Filing and Service of Responsive Documents: Any filing must (1) bear in all capital letters the title ''COMMENTS'', ''PROTEST'', or ''MOTION TO INTERVENE'' as applicable; (2) set forth in the heading the name of the applicant and the project number of the application to which the filing responds; (3) furnish the name, address, and telephone number of the person protesting or intervening; and (4) otherwise comply with the requirements of 18 CFR 385.2001 through 385.2005. All comments, motions to intervene, or protests must set forth their evidentiary basis and otherwise comply with the requirements of 18 CFR 4.34(b). All comments, motions to intervene, or protests should relate to project works which are the subject of the amendment application. Agencies may obtain copies of the application directly from the applicant. A copy of any protest or motion to intervene must be served upon each representative of the applicant specified in the particular application. If an intervener files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency. A copy of all other filings in reference to this application must be accompanied by proof of service on all persons listed in the service list prepared by the Commission in this proceeding, in accordance with 18 CFR 4.34(b) and 385.2010.

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05096 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Commission Staff Attendance

The Federal Energy Regulatory Commission hereby gives notice that members of the Commission's staff may attend the following meetings related to the transmission planning activities of the PJM Interconnection, L.L.C. (PJM):

PJM Planning Committee

March 10, 2016, 9:30 a.m.–12:00 p.m. (EST)

PJM Transmission Expansion Advisory Committee

March 10, 2016, 11:00 a.m.–3:00 p.m. (EST)

The above-referenced meetings will be held at: PJM Conference and Training Center, PJM Interconnection, 2750 Monroe Boulevard, Audubon, PA 19403.

The above-referenced meetings are open to stakeholders.

Further information may be found at *www.pjm.com.*

The discussions at the meetings described above may address matters at issue in the following proceedings:

Docket No. ER16–453, *Northeast Transmission Development, LLC*
Docket No. ER16–736, *PJM Interconnection, L.L.C.*
Docket No. ER14–972, *PJM Interconnection, L.L.C.*
Docket No. ER14–1485, *PJM Interconnection, L.L.C.*
Docket Nos. ER13–1944, *et al., PJM Interconnection, L.L.C., et al.*
Docket No. ER15–1344, *PJM Interconnection, L.L.C.*
Docket No. ER15–1387, *PJM Interconnection, L.L.C. and Potomac Electric Power Company*
Docket No. ER15–2562, *PJM Interconnection, L.L.C.*
Docket No. ER15–2563, *PJM Interconnection, L.L.C.*
Docket No. EL15–18, *Consolidated Edison Company of New York, Inc.* v. *PJM Interconnection, L.L.C.*
Docket No. EL15–41, *Essential Power Rock Springs, LLC, et. al.* v. *PJM Interconnection, L.L.C.*
Docket Nos. ER13–1927, *et al., PJM Interconnection, L.L.C., et al.*
Docket No. ER15–2114, *PJM Interconnection, L.L.C. and Transource West Virginia, LLC*
Docket No. EL15–79, *TransSource, LLC* v. *PJM Interconnection, L.L.C.*
Docket No. EL15–95, *Delaware Public Service Commission, et. al.,* v. *PJM Interconnection, L.L.C., et. al.*
Docket No. EL15–67, *Linden VFT, LLC* v. *PJM Interconnection, L.L.C.*
Docket No. EL05–121, *PJM Interconnection, L.L.C.*
Docket No. ER13–198, *PJM Interconnection, L.L.C.*
Docket No. EC15–157, *Pennsylvania Electric Co., et al.*

For more information, contact the following:

Jonathan Fernandez, Office of Energy Market Regulation, Federal Energy Regulatory Commission, (202) 502–6604, *Jonathan.Fernandez@ferc.gov.*

Alina Halay, Office of Energy Market Regulation, Federal Energy Regulatory Commission, (202) 502–6474, *Alina.Halay@ferc.gov.*

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05095 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER16–1051–000]

Graphic Packaging International Inc.; Supplemental Notice That Initial Market-Based Rate Filing Includes Request for Blanket Section 204 Authorization

This is a supplemental notice in the above-referenced proceeding of Graphic Packaging International Inc.'s application for market-based rate authority, with an accompanying rate tariff, noting that such application includes a request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability.

Any person desiring to intervene or to protest should file with the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant.

Notice is hereby given that the deadline for filing protests with regard to the applicant's request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability, is March 22, 2016.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 5 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426.

The filings in the above-referenced proceeding are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for electronic review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05094 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Filings Instituting Proceedings

Docket Numbers: RP16–648–000.
Applicants: ANR Pipeline Company.
Description: § 4(d) Rate Filing: Vectren Energy Neg Rate Agmts to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5121.
Comments Due: 5 p.m. ET 3/14/16.

Docket Numbers: RP16–649–000.
Applicants: Equitrans, L.P.
Description: § 4(d) Rate Filing: AVC Storage Loss Retainage Factor Update-2016 to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5175.
Comments Due: 5 p.m. ET 3/14/16.

Docket Numbers: RP16–650–000.
Applicants: ANR Pipeline Company.
Description: § 4(d) Rate Filing: Fuel Filing 2016 to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5177.
Comments Due: 5 p.m. ET 3/14/16.

Docket Numbers: RP16–651–000.
Applicants: Texas Eastern Transmission, LP.
Description: § 4(d) Rate Filing: Feb2016 Non-conforming and Negotiated Rate Cleanup to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5194.
Comments Due: 5 p.m. ET 3/14/16.

Docket Numbers: RP16–652–000.
Applicants: Cheniere Creole Trail Pipeline, L.P.

Description: § 4(d) Rate Filing: Annual Charge Adjustment Filing to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5214.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–653–000.
Applicants: Millennium Pipeline Company, LLC.
Description: Operational Transactions Report of Millennium Pipeline Company, LLC.
Filed Date: 2/29/16.
Accession Number: 20160229–5248.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–654–000.
Applicants: Trunkline Gas Company, LLC.
Description: § 4(d) Rate Filing: Fuel Filing on 2–29–16 to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5320.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–655–000.
Applicants: Panhandle Eastern Pipe Line Company, LP.
Description: § 4(d) Rate Filing: Fuel Filing on 2–29–16 to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5327.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–656–000.
Applicants: Southwest Gas Storage Company.
Description: § 4(d) Rate Filing: Fuel Filing on 2–29–16 to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5331.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–657–000.
Applicants: Dominion Transmission, Inc.
Description: § 4(d) Rate Filing: DTI—February 29, 2016, Nonconforming Service Agreement to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5344.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–658–000.
Applicants: Tennessee Gas Pipeline Company, L.L.C.
Description: § 4(d) Rate Filing: Fuel Tracker 2016 to be effective 2/29/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5347.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–659–000.
Applicants: Iroquois Gas Transmission System, L.P.
Description: § 4(d) Rate Filing: 02/29/16 Negotiated Rates—Macquarie Energy LLC (RTS) 4090–12 to be effective 3/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5369.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–660–000.
Applicants: Dominion Cove Point LNG, LP.
Description: § 4(d) Rate Filing: DCP—2016 Annual EPCA to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5376.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–661–000.
Applicants: Equitrans, L.P.
Description: § 4(d) Rate Filing: 3–1–2016 Formula-Based Negotiated Rates to be effective 3/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5377.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–662–000.
Applicants: Rockies Express Pipeline LLC.
Description: § 4(d) Rate Filing: Neg Rate 2016–02–29 Encana to be effective 3/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5379.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–663–000.
Applicants: Natural Gas Pipeline Company of America.
Description: § 4(d) Rate Filing: Mercuria Energy Gas Trading LLC 146663–NSSANGPL to be effective 3/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5380.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–664–000.
Applicants: Dominion Cove Point LNG, LP.
Description: § 4(d) Rate Filing: DCP—2016 Annual Fuel Retainage to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5382.
Comments Due: 5 p.m. ET 3/14/16.
Docket Numbers: RP16–665–000.
Applicants: Florida Gas Transmission Company, LLC.
Description: § 4(d) Rate Filing: Fuel Filing on 2–29–16 to be effective 4/1/2016.
Filed Date: 2/29/16.
Accession Number: 20160229–5390.
Comments Due: 5 p.m. ET 3/14/16.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and § 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated March 1, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05093 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. CP15–18–000; CP15–18–001; CP15–498–000]

Eastern Shore Natural Gas Company; Notice of Revised Schedule for Environmental Review of the White Oak Mainline Expansion Project and System Reliability Project

This notice identifies the Federal Energy Regulatory Commission staff's revised schedule for the completion of the environmental assessment (EA) for Eastern Shore Natural Gas Company's (Eastern Shore) White Oak Mainline Expansion Project and System Reliability Project. The original notice of schedule, issued on February 10, 2016, identified April 12, 2016 as the EA issuance date. However, staff has revised the schedule for issuance of the EA.

SCHEDULE FOR ENVIRONMENTAL REVIEW

Issuance of EA	April 25, 2016.
90-Day Federal Authorization Decision Deadline.	July 24, 2016.

If a schedule change becomes necessary, an additional notice will be provided so that the relevant agencies are kept informed of the projects' progress.

Additional Information

In order to receive notification of the issuance of the EA and to keep track of all formal issuances and submittals in specific dockets, the Commission offers a free service called eSubscription (*http://www.ferc.gov/docs-filing/esubscription.asp*). Additional information about the project may be

obtained by contacting the Environmental Project Manager, Gertrude Johnson, by telephone at 202–502–6692 or by electronic mail at *gertrude.fernandez.johnson@ferc.gov.*

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05097 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following electric corporate filings:

Docket Numbers: EC16–58–000.

Applicants: ReEnergy Sterling CT Limited Partnership.

Description: Response to Commission Staff's request for supplemental information of ReEnergy Sterling CT Limited Partnership.

Filed Date: 2/25/16.

Accession Number: 20160225–5100.

Comments Due: 5 p.m. ET 3/07/16.

Docket Numbers: EC16–84–000.

Applicants: Kingbird Solar A, LLC, Kingbird Solar B, LLC.

Description: Application for Authorization Under Section 203 of the Federal Power Act and Request for Expedited Action, Confidential Treatment, and Waivers of Kingbird Solar A, LLC, et al.

Filed Date: 3/1/16.

Accession Number: 20160301–5443.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: EC16–85–000.

Applicants: Comanche Solar PV, LLC.

Description: Application for Authorization Under Section 203 of the Federal Power Act and Request for Waivers, Expedited Action, Shortened Comment Period, and Confidential Treatment of Comanche Solar PV, LLC.

Filed Date: 3/1/16.

Accession Number: 20160301–5514.

Comments Due: 5 p.m. ET 3/22/16.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER13–1937–003.

Applicants: Southwest Power Pool, Inc.

Description: Compliance filing: Order No. 1000 Interregional SPP–MISO JOA Third Compliance Filing to be effective 3/30/2014.

Filed Date: 3/1/16.

Accession Number: 20160301–5222.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER13–1938–002.

Applicants: Midcontinent Independent System Operator, Inc.

Description: Compliance filing: 2016–03–01_MISO–SPP Order 1000 Compliance (2/2/2016 Order) to be effective 3/30/2014.

Filed Date: 3/1/16.

Accession Number: 20160301–5336.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER14–154–004; ER14–153–004; ER10–3143–016; ER10–2742–007.

Applicants: Gibson City Energy Center, LLC, Grand Tower Energy Center, LLC, Lakeswind Power Partners, LLC, Sabine Cogen, LP, Tilton Energy LLC.

Description: Second Amendment to June 26, 2015 Triennial Market-Based Rate Update Filing for the Central Region of the Rockland Sellers.

Filed Date: 3/1/16.

Accession Number: 20160301–5185.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER14–199–001.

Applicants: Lakewood Cogeneration, L.P.

Description: Compliance filing: Informational Filing of the Essential Power Companies to be effective N/A.

Filed Date: 3/1/16.

Accession Number: 20160301–5401.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER14–714–001.

Applicants: Essential Power Rock Springs, LLC.

Description: Compliance filing: Information Filing of the Essential Power Companies to be effective N/A.

Filed Date: 3/1/16.

Accession Number: 20160301–5403.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER14–715–001.

Applicants: Essential Power OPP, LLC.

Description: Compliance filing: Information Filing of the Essential Power Companies to be effective N/A.

Filed Date: 3/1/16.

Accession Number: 20160301–5400.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER16–1051–000.

Applicants: Graphic Packaging International, Inc.

Description: Baseline eTariff Filing: Application for Initial Market-Based Rate Tariff and Granting Certain Waivers to be effective 3/1/2016.

Filed Date: 3/1/16.

Accession Number: 20160301–5387.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER16–1052–000.

Applicants: HollyFrontier El Dorado Refining LLC.

Description: Tariff Cancellation: Notice of Cancellation of Market-Based Rate Tariff to be effective 3/1/2016.

Filed Date: 3/1/16.

Accession Number: 20160301–5394.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER16–1053–000.

Applicants: HollyFrontier El Dorado Refining LLC.

Description: Compliance filing: Refiling of Baseline Market-Based Rate Tariff to be effective 3/1/2016.

Filed Date: 3/1/16.

Accession Number: 20160301–5397.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER16–1054–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: East Texas Cooperatives Stated Rate to be effective 5/1/2016.

Filed Date: 3/1/16.

Accession Number: 20160301–5410.

Comments Due: 5 p.m. ET 3/22/16.

Docket Numbers: ER16–1055–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Original WMPA SA No. 4418, Queue No. AA2–123 to be effective 2/17/2016.

Filed Date: 3/2/16.

Accession Number: 20160302–5053.

Comments Due: 5 p.m. ET 3/23/16.

Docket Numbers: ER16–1056–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: § 205(d) Rate Filing: 2016–03–02_SA 2899 ITC Midwest-Northern States Power FCA (J278) to be effective 3/3/2016.

Filed Date: 3/2/16.

Accession Number: 20160302–5093.

Comments Due: 5 p.m. ET 3/23/16.

Docket Numbers: ER16–1057–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: Compliance filing: 2016–03–02_SA 6507_White Pine 1 SSR Settlement to be effective 6/1/2015.

Filed Date: 3/2/16.

Accession Number: 20160302–5099.

Comments Due: 5 p.m. ET 3/23/16.

Docket Numbers: ER16–1058–000.

Applicants: Consumers Energy Company.

Description: § 205(d) Rate Filing: Amendment to Rate Schedule No. 116 to be effective 5/1/2016.

Filed Date: 3/2/16.

Accession Number: 20160302–5149.

Comments Due: 5 p.m. ET 3/23/16.

Docket Numbers: ER16–1059–000.

Applicants: Cleco Power LLC.

Description: § 205(d) Rate Filing: amendments to Cleco Power Rate Schedule FERC No. 35 to be effective 3/3/2016.

Filed Date: 3/2/16.

Accession Number: 20160302–5152.

Comments Due: 5 p.m. ET 3/23/16.

Docket Numbers: ER16–1060–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Original Service Agreement No. 4412; NQ–134 (ISA) to be effective 2/1/2016.

Filed Date: 3/2/16.

Accession Number: 20160302–5153.

Comments Due: 5 p.m. ET 3/23/16.

Docket Numbers: ER16–1061–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: 1534R5 Kansas Municipal Energy Agency NITSA NOA to be effective 2/1/2016.

Filed Date: 3/2/16.

Accession Number: 20160302–5155.

Comments Due: 5 p.m. ET 3/23/16.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: March 2, 2016.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2016–05092 Filed 3–7–16; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2015–0437; FRL–9942–87]

Agency Information Collection Activities; Proposed Renewal of an Existing Collection (EPA ICR No. 2302.03); Comment Request

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA), this document announces that EPA is planning to submit an Information Collection Request (ICR) to the Office of Management and Budget (OMB). The ICR, entitled: ''Safer Choice Product Recognition Program'' and identified by EPA ICR No. 2302.03 and OMB Control No. 2070–0178, represents the renewal of an existing ICR that is scheduled to expire on August 31, 2016. Before submitting the ICR to OMB for review and approval, EPA is soliciting comments on specific aspects of the proposed information collection that is summarized in this document. The ICR and accompanying material are available in the docket for public review and comment.

DATES: Comments must be received on or before May 9, 2016.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPPT–2015–0437, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.
- *Mail:* Document Control Office (7407M), Office of Pollution Prevention and Toxics (OPPT), Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *http://www.epa.gov/dockets/contacts.html.*

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: *For technical information contact:* Chen Wen, Chemistry, Economics & Sustainable Strategies Division (7409M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001; telephone number: (202) 564–8849; email address: *wen.chen@epa.gov.*

For general information contact: The TSCA-Hotline, ABVI-Goodwill, 422 South Clinton Ave., Rochester, NY 14620; telephone number: (202) 554–1404; email address: *TSCA-Hotline@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. What information is EPA particularly interested in?

Pursuant to PRA section 3506(c)(2)(A) (44 U.S.C. 3506(c)(2)(A)), EPA specifically solicits comments and information to enable it to:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility.

2. Evaluate the accuracy of the Agency's estimates of the burden of the proposed collection of information, including the validity of the methodology and assumptions used.

3. Enhance the quality, utility, and clarity of the information to be collected.

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses. In particular, EPA is requesting comments from very small businesses (those that employ less than 25) on examples of specific additional efforts that EPA could make to reduce the paperwork burden for very small businesses affected by this collection.

II. What information collection activity or ICR does this action apply to?

Title: Safer Choice Product Recognition Program.

ICR number: EPA ICR No. 2302.03.

OMB control number: OMB Control No. 2070–0178.

ICR status: This ICR is currently scheduled to expire on August 31, 2016. An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations in title 40 of the Code of Federal Regulations (CFR), after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers for certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: EPA's Safer Choice program formally recognizes safer products where all ingredients have an environmental and human health profile showing that they are the safest in their functional use class. Under the encouragement of this program, leading companies have made great progress in developing safer, highly effective chemical products. Since the program's inception in 1997, formulators have used the program as a portal to EPA's unique chemical expertise, information resources, and guidance on greener

chemistry. Safer Choice program partners enjoy Agency recognition, including the use of the Safer Choice program logo on products with the safest possible formulations. In the future, EPA expects much greater program participation due to rising demand for safer products. This information collection enables EPA to accommodate participation by more than nine formulators each year and to enhance program transparency.

Information collection activities associated with this program will assist the Agency in meeting the goals of the Pollution Prevention Act (PPA) by providing resources and recognition for businesses committed to promoting and using safer chemical products. In turn, the program will help businesses meet corporate sustainability goals by providing the means to, and an objective measure of, environmental stewardship. Investment analysts and advisers seek these types of measures in evaluating a corporation's sustainability profile and investment worthiness. Safer Choice Product Recognition program partnership is an important impetus for prioritizing and completing the transition to safer chemical products. The Safer Choice Product Recognition program is also needed to promote greater use of safer chemical products by companies unaware of the benefits of such a change.

EPA has tailored its request for information, and especially the Safer Choice Product Recognition program application forms, to ensure that the Agency requests only that information essential to verify applicants' eligibility for recognition.

Responses to the collection of information are voluntary. Respondents may claim all or part of a response confidential. EPA will disclose information that is covered by a claim of confidentiality only to the extent permitted by, and in accordance with, the procedures in TSCA section 14 and 40 CFR part 2.

Burden statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to range between 8 and 16 hours per response, depending upon the type of respondent. Burden is defined in 5 CFR 1320.3(b).

The ICR, which is available in the docket along with other related materials, provides a detailed explanation of the collection activities and the burden estimate that is only briefly summarized here:

Respondents/Affected Entities: Entities potentially affected by this ICR are companies engaged in the formulation of end-use, for-sale products that have furthered the goals of the Safer Choice program through active and exemplary participation in and promotion of the program, and that wish to receive recognition for their achievements.

Estimated total number of potential respondents: 157.

Frequency of response: On occasion.

Estimated total average number of responses for each respondent: 1.0.

Estimated total annual burden hours: 1,596 hours.

Estimated total annual costs: $652,359. This includes an estimated burden cost of $ 652,359 and an estimated cost of $ 0 for capital investment or maintenance and operational costs.

III. Are there changes in the estimates from the last approval?

There is an increase of 362 hours in the total estimated respondent burden compared with that identified in the ICR currently approved by OMB. This increase reflects EPA's estimate of a greater number of respondents, due to historical experience and increases in the expected future number of responses due to greater consumer awareness and demand for products with the Safer Choice label. This increase is partially offset by reduced per-response burden estimates based on expected efficiencies created by using the Salesforce-based Safer Choice Community on the part of respondents. This change is an adjustment.

IV. What is the next step in the process for this ICR?

EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval pursuant to 5 CFR 1320.12. EPA will issue another **Federal Register** document pursuant to 5 CFR 1320.5(a)(1)(iv) to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB. If you have any questions about this ICR or the approval process, please contact the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 44 U.S.C. 3501 *et seq.*

Dated: March 1, 2016.

Louise P. Wise,

Acting Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

[FR Doc. 2016–05175 Filed 3–7–16; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2015–0084; FRL–9942–68]

1-Bromopropane (1–BP); Availability of TSCA Work Plan Chemical Risk Assessment for Public Review and Comment

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: With this notice, EPA is announcing the availability of and opening the public comment period for the draft TSCA Work Plan Chemical risk assessment for 1-Bromopropane (1–BP). EPA develops TSCA Work Plan Chemical assessments using the best available information and approaches. These assessments focus on those TSCA uses of the chemical with significant potential for exposure to humans and/or the environment. EPA issues draft risk assessments for public review and comment, followed by independent peer review in accordance with Agency peer review guidelines. The Agency considers all public and peer review comments as it revises and finalizes the risk assessment. Based on the final TSCA risk assessment, the Agency may either initiate risk reduction actions that are necessary to address the potential risks identified, or may conclude its work on the chemical uses being assessed if no risks are found.

DATES: Comments must be received on or before May 9, 2016.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPPT–2015–0084, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.
- *Mail:* Document Control Office (7407M), Office of Pollution Prevention and Toxics (OPPT), Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at: *http://www.epa.gov/dockets/contacts.html.*

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, are available at *http://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: *For technical information contact:* Stan

Barone, Risk Assessment Division (7403M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001; telephone number: (202) 564–1169; email address: *barone.stan@epa.gov.*

For general information contact: The TSCA-Hotline, ABVI-Goodwill, 422 South Clinton Ave., Rochester, NY 14620; telephone number: (202) 554–1404; email address: *TSCA-Hotline@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

This action is directed to the public in general, and may be of interest to a wide range of stakeholders including those interested in environmental and human health; the chemical industry; chemical users; consumer product companies and members of the public interested in the assessment of chemical risks. Since others also may be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action.

B. What should I consider as I prepare my comments for EPA?

1. *Submitting CBI.* Do not submit this information to EPA through regulations.gov or email. Clearly mark the part or all of the information that you claim to be CBI. For CBI information on a disk or CD–ROM that you mail to EPA, mark the outside of the disk or CD–ROM as CBI and then identify electronically within the disk or CD–ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for preparing your comments.* When preparing and submitting your comments, see the commenting tips at *http://www.epa.gov/dockets/comments.html.*

II. What action is the Agency taking?

EPA is announcing the availability of and opening the public comment period for the 1-Bromopropane (1–BP) TSCA Work Plan Chemical draft risk assessment. EPA also invites comments on whether there are other uses that may result in high potential worker and consumer exposures that the Agency should consider for future assessment and/or collection priorities for this chemical. Use the specific docket ID number provided in this notice to locate a copy of the chemical-specific document, as well as to submit comments via *http://www.regulations.gov.*

Docket ID Number: EPA–HQ–OPPT–2015–0084.

Title: TSCA Work Plan Chemical Risk Assessment for 1-Bromopropane (*n*-Propyl Bromide): Spray adhesives, dry cleaning, and degreasing uses.

Chemical Covered: 1-Bromopropane (*n*-Propyl Bromide) (1–BP; CASRN 106–94–5).

Summary: 1–BP is a colorless liquid with a sweet hydrocarbon odor that is used as a solvent in degreasing applications, spray adhesives, and in dry cleaning. 1–BP is produced or imported to the U.S. in large quantities (over 15 million pounds in 2011). This draft assessment focuses on human health risks to workers and consumers from acute (short-term) and chronic inhalation exposures associated with 1–BP use in spray adhesives, dry cleaning, and degreasing uses. EPA reviewed the evidence for 1–BP toxicity and identified risks for cancer (in workers) and adverse developmental effects (in consumers and workers). Other health risks identified for workers with chronic 1–BP exposures include adverse neurologic effects, as well as kidney, liver, and reproductive effects.

If you have any questions about this draft risk assessment, or the Agency's programs in general, please contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 15 U.S.C. 2601 *et. seq.*

Dated: March 2, 2016.

Wendy C. Hamnett,

Director, Office of Pollution Prevention and Toxics.

[FR Doc. 2016–05176 Filed 3–7–16; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2016–0062; FRL–9942–63]

FIFRA Scientific Advisory Panel; Notice of Public Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: There will be a 3-day meeting of the Federal Insecticide, Fungicide, and Rodenticide Act Scientific Advisory Panel (FIFRA SAP) to consider and review Chlorpyrifos: Analysis of Biomonitoring Data.

DATES: The meeting will be held on April 19–21, 2016, from approximately 9 a.m. to 5 p.m.

Comments. The Agency encourages written comments be submitted on or before April 5, 2016, and requests for oral comments be submitted on or before April 12, 2016. However, written comments and requests to make oral comments may be submitted until the date of the meeting, but anyone submitting written comments after April 5, 2016, should contact the Designated Federal Official (DFO) listed under **FOR FURTHER INFORMATION CONTACT**. For additional instructions, see Unit I.C. of the **SUPPLEMENTARY INFORMATION**.

Nominations. Nominations of candidates to serve as ad hoc members of FIFRA SAP for this meeting should be provided on or before March 23, 2016.

Webcast. This meeting may be webcast. Please refer to the FIFRA SAP Web site at *http://www.epa.gov/sap* for information on how to access the meeting webcast. Please note that the webcast is a supplementary public process provided only for convenience. If difficulties arise resulting in webcasting outages, the meeting will continue as planned.

Special accommodations. For information on access or services for individuals with disabilities, and to request accommodation of a disability, please contact the DFO listed under **FOR FURTHER INFORMATION CONTACT** at least 10 days prior to the meeting to give EPA as much time as possible to process your request.

ADDRESSES: *Meeting:* The meeting will be held at the Environmental Protection Agency, Conference Center, Lobby Level, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA 22202.

Comments. Submit your comments, identified by docket identification (ID) number EPA–HQ–OPP–2016–0062, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.
- *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand-delivery or delivery of boxed information, please

follow the instructions at *http://www.epa.gov/dockets/contacts.html.* Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets.*

Nominations, requests to present oral comments, and requests for special accommodations. Submit nominations to serve as ad hoc members of FIFRA SAP, requests for special accommodations, or requests to present oral comments to the DFO listed under **FOR FURTHER INFORMATION CONTACT**.

FOR FURTHER INFORMATION CONTACT: Fred Jenkins, DFO, Office of Science Coordination and Policy (7201M), Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460–0001; telephone number: (202) 564–3327; email address: *jenkins.fred@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

This action is directed to the public in general. This action may, however, be of interest to persons who are or may be required to conduct testing of chemical substances under the Federal Food, Drug, and Cosmetic Act (FFDCA) and FIFRA. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action.

B. What should I consider as I prepare my comments for EPA?

1. *Submitting CBI.* Do not submit CBI information to EPA through regulations.gov or email. If your comments contain any information that you consider to be CBI or otherwise protected, please contact the DFO listed under **FOR FURTHER INFORMATION CONTACT** to obtain special instructions before submitting your comments.

2. *Tips for preparing your comments.* When preparing and submitting your comments, see the commenting tips at *http://www.epa.gov/dockets/comments.html.*

C. How may I participate in this meeting?

You may participate in this meeting by following the instructions in this unit. To ensure proper receipt by EPA, it is imperative that you identify docket ID number EPA–HQ–OPP–2016–0062 in the subject line on the first page of your request.

1. *Written comments.* The Agency encourages written comments be submitted, using the instructions in **ADDRESSES** and Unit I.B., on or before April 5, 2016, to provide FIFRA SAP the time necessary to consider and review the written comments. Written comments are accepted until the date of the meeting, but anyone submitting written comments after April 5, 2016, should contact the DFO listed under **FOR FURTHER INFORMATION CONTACT**. Anyone submitting written comments at the meeting should bring 30 copies for distribution to FIFRA SAP.

2. *Oral comments.* The Agency encourages each individual or group wishing to make brief oral comments to FIFRA SAP submit their request to the DFO listed under **FOR FURTHER INFORMATION CONTACT** on or before April 12, 2016, to be included on the meeting agenda. Requests to present oral comments will be accepted until the date of the meeting and, to the extent that time permits, the Chair of FIFRA SAP may permit the presentation of oral comments at the meeting by interested persons who have not previously requested time. The request should identify the name of the individual making the presentation, the organization (if any) the individual will represent and any requirements for audiovisual equipment. Oral comments before FIFRA SAP are limited to approximately 5 minutes unless prior arrangements have been made. In addition, each speaker should bring 30 copies of his or her comments and presentation for distribution to FIFRA SAP at the meeting.

3. *Seating at the meeting.* Seating at the meeting will be open and on a first-come basis.

4. *Request for nominations to serve as ad hoc members of FIFRA SAP for this meeting.* As part of a broader process for developing a pool of candidates for each meeting, FIFRA SAP staff routinely solicits the stakeholder community for nominations of prospective candidates for service as ad hoc members of FIFRA SAP. Any interested person or organization may nominate qualified individuals to be considered as prospective candidates for a specific meeting. Individuals nominated for this meeting should have expertise in one or more of the following areas: Human biomonitoring data and interpretation of such data; epidemiology (particularly reproductive/developmental, and environmental), exposure assessment of pesticides (residential and agricultural worker); route-specific pharmacokinetics (dermal, oral); physiologically-based pharmacokinetic modeling (PBPK); cholinergic and non-cholinergic mechanisms; cholinesterase inhibition; developmental neurotoxicity; human health risk assessment; organophosphate pesticides; and pharmacokinetics. [**Note:** In support of the U.S. Environmental Protection Agency's (EPA) priority of ''Making a Visible Difference in Communities'' across the country, the Agency is committed to helping minority, low-income, tribal and other vulnerable populations improve their health and environment. In an effort to ensure that the Agency's proposed actions are taking into consideration input from potential communities with environmental justice concerns, the EPA is offering an opportunity to provide input on the FIFRA SAP meeting to address scientific issues associated with ''Chlorpyrifos: Analysis of Biomonitoring Data.'' The EPA encourages all grass-roots organizations and residents to submit public comments on this issue that is being addressed during the FIFRA Scientific Advisory Panel meeting. The Agency also encourages community environmental justice advocates to give a voice to their communities by nominating candidates for consideration to serve on this panel.] Nominees should be scientists who have sufficient professional qualifications, including training and experience, to provide expert comments on the scientific issues for this meeting. Nominees should be identified by name, occupation, position, address, email address, and telephone number. Nominations should be provided to the DFO listed under **FOR FURTHER INFORMATION CONTACT** on or before March 23, 2016. The Agency will consider all nominations of prospective candidates for this meeting that are received on or before that date. However, final selection of ad hoc members for this meeting is a discretionary function of the Agency.

The selection of scientists to serve on FIFRA SAP is based on the function of the Panel and the expertise needed to address the Agency's charge to the Panel. No interested scientists shall be ineligible to serve by reason of their membership on any other advisory committee to a Federal department or agency, or their employment by a Federal department or agency except EPA. Other factors considered during the selection process include availability of the potential Panel member to fully participate in the Panel's reviews, absence of any conflicts of interest or appearance of lack of impartiality, independence with respect to the matters under review, and lack of bias. Although financial conflicts of interest, the appearance of lack of impartiality, lack of independence, and bias may result in disqualification, the

absence of such concerns does not assure that a candidate will be selected to serve on the FIFRA SAP. Numerous qualified candidates are identified for each Panel. Therefore, selection decisions involve carefully weighing a number of factors including the candidates' areas of expertise and professional qualifications and achieving an overall balance of different scientific perspectives on the Panel. The Agency anticipates selecting approximately 8 ad hoc scientists to have the collective breadth of experience needed to address the Agency's charge for this meeting.

FIFRA SAP members are subject to the provisions of 5 CFR part 2634—Executive Branch Financial Disclosure, Qualified Trusts, and Certificates of Divestiture, as supplemented by EPA in 5 CFR part 6401. In anticipation of this requirement, prospective candidates for service on FIFRA SAP will be asked to submit confidential financial information which shall fully disclose, among other financial interests, the candidate's employment, stocks, and bonds, and where applicable, sources of research support. EPA will evaluate the candidates' financial disclosure form to assess whether there are financial conflicts of interest, appearance of a lack of impartiality, or any prior involvement with the development of the documents under consideration (including previous scientific peer review) before the candidate is considered further for service on the FIFRA SAP. Those who are selected from the pool of prospective candidates will be asked to attend the public meetings and to participate in the discussion of key issues and assumptions at these meetings. In addition, they will be asked to review and to help finalize the meeting minutes. The list of FIFRA SAP members participating at this meeting will be posted on the FIFRA SAP Web site at *http://www.epa.gov/scipoly/sap* or may be obtained from the OPP Docket at *http://www.regulations.gov.*

II. Background

A. Purpose of FIFRA SAP

FIFRA SAP serves as the primary scientific peer review mechanism of EPA's Office of Chemical Safety and Pollution Prevention (OCSPP) and is structured to provide scientific advice, information and recommendations to the EPA Administrator on pesticides and pesticide-related issues as to the impact of regulatory actions on health and the environment. FIFRA SAP is a Federal advisory committee established in 1975 under FIFRA that operates in accordance with requirements of the Federal Advisory Committee Act (5 U.S.C. Appendix). FIFRA SAP is composed of a permanent panel consisting of seven members who are appointed by the EPA Administrator from nominees provided by the National Institutes of Health and the National Science Foundation. FIFRA established a Science Review Board (SRB) consisting of at least 60 scientists who are available to the FIFRA SAP on an ad hoc basis to assist in reviews conducted by FIFRA SAP. As a scientific peer review mechanism, FIFRA SAP provides comments, evaluations and recommendations to improve the effectiveness and quality of analyses made by Agency scientists. Members of the FIFRA SAP are scientists who have sufficient professional qualifications, including training and experience, to provide expert advice and recommendation to the Agency.

B. Public Meeting

Chlorpyrifos (0,0-diethyl-0-3,5,6-trichloro-2-pyridyl phosphorothioate) is a broad-spectrum, chlorinated organophosphate (OP) insecticide. The FIFRA SAP previously reviewed the human health effects of chlorpyrifos in 2008 and 2012, and the chlorpyrifos physiologically-based pharmacokinetic/pharmacodynamic (PBPK/PD) model in 2011. At the 2008 and 2012 SAP meetings, the Agency presented information on a variety of science issues such as inhibition of the enzyme acetylcholinesterase (AChE) in the nervous system, epidemiology studies in infants and children which suggest that chlorpyrifos and other OPs impact neurodevelopment, and a growing body of literature with laboratory animals (rats and mice) indicating that gestational and/or early postnatal exposure to chlorpyrifos may cause persistent effects into adulthood. Like other OPs, chlorpyrifos binds to and phosphorylates the enzyme acetylcholinesterase (AChE) in both the central (brain) and peripheral nervous systems. This can lead to accumulation of acetylcholine and ultimately, at sufficiently high doses, to clinical signs of toxicity. As recommended by the FIFRA SAP in 2008 and 2012, the Agency used inhibition of AChE as the critical effect to derive points of departure for the 2014 human health risk assessment. However, the 2014 human health risk assessment identified uncertainty in the degree to which points of departure derived from AChE inhibition are protective for neurodevelopmental effects in humans.

In 2008 and 2012, the FIFRA SAP cautioned the Agency against using the biomonitoring data from epidemiology studies, particularly those from Columbia University in this case, to directly derive points of departure due to uncertainties associated with a lack of knowledge about timing of indoor chlorpyrifos applications and a single measure of exposure (cord blood) which were collected by the Columbia researchers. The concern is that single measures of exposure may not reflect the entire pregnancy or temporal exposure uncertainty coupled with unknown windows of susceptibility. The 2012 SAP recommended that the Agency consider use of a PBPK model to further characterize the dose estimates in the epidemiology studies. Based on human health risks identified in the 2014 human health risk assessment, the Agency published a 2015 proposed tolerance revocation for chlorpyrifos; in that proposal the Agency noted that the evaluation of the available biomonitoring was continuing. While EPA would have preferred to complete that analysis prior to commencing rulemaking, the timing for the proposal was directed by the U.S. Court of Appeals for the 9th Circuit, which ordered EPA to respond to an administrative petition to revoke all chlorpyrifos tolerances by October 31, 2015. In any case, at this point in time, the Agency's analysis of biomonitoring data from cord blood collected as part of the Columbia University epidemiology studies has progressed to a point where peer review would be useful. Specifically, the Agency has done additional characterization of the pharmacokinetic profile of simulated exposures from oral and dermal exposures using the PBPK model. Based on this evaluation, the Agency now believes the cord blood data are sufficiently robust for deriving points of departure. The Agency will solicit comment from the SAP on the evaluation of biomonitoring data using the PBPK model, proposed points of departure and extrapolation/uncertainty factors, and examples of a proposed approach to use the PBPK model to simulate internal doses from current exposure patterns from drinking water, food and worker exposure.

C. FIFRA SAP Documents and Meeting Minutes

EPA's background paper, related supporting materials, charge/questions to FIFRA SAP, FIFRA SAP composition (*i.e.,* members and ad hoc members for this meeting), and the meeting agenda will be available by approximately mid-March. In addition, the Agency may provide additional background documents as the materials become

available. You may obtain electronic copies of these documents and certain other related documents that might be available at *http://www.regulations.gov* and the FIFRA SAP Web site at *http://www.epa.gov/scipoly/sap.*

FIFRA SAP will prepare meeting minutes summarizing its recommendations to the Agency approximately 90 days after the meeting. The meeting minutes will be posted to the FIFRA SAP Web site or may be obtained from the OPP Docket at *http://www.regulations.gov.*

Authority: 7 U.S.C. 136 *et seq.;* 21 U.S.C. 301 *et seq.*

Dated: February 26, 2016.

David J. Dix,

Director, Office of Science Coordination and Policy.

[FR Doc. 2016–05174 Filed 3–7–16; 8:45 am]

BILLING CODE 6560–50–P

EXPORT-IMPORT BANK

[Public Notice: 2016–6021]

Agency Information Collection Activities: Comment Request

AGENCY: Export-Import Bank of the United States.

ACTION: Submission for OMB review and comments request.

Form Title: EIB 10–06 Application for Approved Finance Provider.

SUMMARY: The Export-Import Bank of the United States (EXIM Bank), as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal Agencies to comment on the proposed information collection, as required by the Paperwork Reduction Act of 1995.

Financial institutions interested in becoming an Approved Finance Provider (AFP) with EXIM Bank must complete this application in order to obtain approval to make loans under EXIM Bank insurance policies and/or enter into one or more Master Guarantee Agreements (MGA) with EXIM Bank. An AFP may participate in the Medium-Term Insurance, Bank Letter of Credit, and Financial Institution Buyer Credit programs as an insured lender, while AFPs approved for an MGA may apply for multiple loan or lease transactions to be guaranteed by EXIM Bank.

EXIM Bank uses the information provided in the form and the supplemental information required to be submitted with the form to determine whether the lender qualifies to participate in its lender insurance and guarantee programs. The details are necessary to evaluate whether the lender has the capital to fund potential transactions, proper due diligence procedures, and the monitoring capacity to carry out transactions.

The information collection tool can be reviewed at: *http://exim.gov/sites/default/files/pub/pending/eib10_06.pdf.*

DATES: Comments must be received on or before May 9, 2016 to be assured of consideration.

ADDRESSES: Comments may be submitted electronically on *WWW.REGULATIONS.GOV* or by mail to Michele Kuester, Export-Import Bank, 811 Vermont Ave. NW., Washington, DC 20571

SUPPLEMENTARY INFORMATION:

Title and Form Number: EIB 10–06 Application for Approved Finance Provider.

OMB Number: 3048–0032.

Type of Review: Regular.

Need and Use: The information collected will allow EXIM Bank to determine compliance and content for transaction requests submitted to the Export-Import Bank under its insurance, guarantee, and direct loan programs.

Affected Public: This form affects entities involved in the export of U.S. goods and services.

Annual Number of Respondents: 50.

Estimated Time per Respondent: 30 minutes.

Annual Burden Hours: 25 hours.

Frequency of Reporting of Use: On occasion.

Government Expenses:

Reviewing time per year: 25 hours.

Average Wages per Hour: $42.50.

Average Cost per Year: $1,062.50. (time*wages)

Benefits and Overhead: 20%.

Total Government Cost: $1,275.

Bonita Jones-McNeil,

Program Analyst, Agency Clearance Officer, Office of the Chief Information Officer.

[FR Doc. 2016–05102 Filed 3–7–16; 8:45 am]

BILLING CODE 6690–01–P

FEDERAL COMMUNICATIONS COMMISSION

[OMB 3060–0261]

Information Collection Being Reviewed by the Federal Communications Commission Under Delegated Authority

AGENCY: Federal Communications Commission.

ACTION: Notice and request for comments.

SUMMARY: As part of its continuing effort to reduce paperwork burdens, and as required by the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501–3520), the Federal Communications Commission (FCC or the Commission) invites the general public and other federal agencies to take this opportunity to comment on the following information collection. Comments are requested concerning: Whether the collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; the accuracy of the Commission's burden estimate; ways to enhance the quality, utility, and clarity of the information collected; ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology; and ways to further reduce the information collection burden on small business concerns with fewer than 25 employees.

The FCC may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid Office of Management and Budget (OMB) control number.

DATES: Written PRA comments should be submitted on or before May 9, 2016. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Cathy Williams, FCC, via email *PRA@fcc.gov* and to *Cathy.Williams@fcc.gov.*

FOR FURTHER INFORMATION CONTACT: For additional information about the information collection, contact Cathy Williams at (202) 418–2918.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0261.

Title: Section 90.215, Transmitter Measurements.

Form No.: Not applicable.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit, not-for-profit institutions and state, local or tribal Government.

Number of Respondents: 19,570 respondents; 25,558 responses.

Estimated Time per Response: .034 hours.

Frequency of Response: Recordkeeping requirement.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this information collection

is contained in 47 U.S.C. 303(f) of the Communications Act of 1934, as amended.

Total Annual Burden: 869 hours.

Total Annual Cost: No cost.

Privacy Act Impact Assessment: No impact(s).

Nature and Extent of Confidentiality: There is no need for confidentiality with this collection of information.

Needs and Uses: Section 90.215 requires station licensees to measure the carrier frequency, output power, and modulation of each transmitter authorized to operate with power in excel of two watts when the transmitter is initially installed and when any changes are made which would likely affect the modulation characteristics. Such measurements, which help ensure proper operation of transmitters, are to be made by a qualified engineering measurement service, and are required to be retained in the station records, along with the name and address of the engineering measurement service, and the name of the person making the measurements.

The information is normally used by the licensee to ensure that equipment is operating within prescribed tolerances. Prior technical operation of transmitters helps limit interference to other users and provides the licensee with the maximum possible utilization of equipment.

Federal Communications Commission.

Marlene H. Dortch,

Secretary, Office of the Secretary.

[FR Doc. 2016–05013 Filed 3–7–16; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL RESERVE SYSTEM

Notice of Proposals To Engage in or To Acquire Companies Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y, (12 CFR part 225) to engage *de novo,* or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than March 22, 2016.

A. Federal Reserve Bank of St. Louis (Yvonne Sparks, Community Development Officer) P.O. Box 442, St. Louis, Missouri 63166–2034:

1. *Paducah Bank Shares, Inc.* Paducah, Kentucky; to engage directly in credit related activities, pursuant to section 225.28(b)(1) of Regulation Y.

Board of Governors of the Federal Reserve System, March 2, 2016.

Michael J. Lewandowski,

Assistant Secretary of the Board.

[FR Doc. 2016–05050 Filed 3–7–16; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than March 22, 2016.

A. Federal Reserve Bank of Kansas City (Dennis Denney, Assistant Vice President) 1 Memorial Drive, Kansas City, Missouri 64198–0001:

1. *John William Landwehr, Richmond, Missouri;* to acquire voting shares as a part of Landwehr Family Group of Missouri Bancorp, Inc., Richmond, Missouri, and thereby indirectly acquire voting shares of Community Bank of Missouri, Richmond, Missouri.

Board of Governors of the Federal Reserve System, March 2, 2016.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2016–05048 Filed 3–7–16; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than March 31, 2016.

A. Federal Reserve Bank of Atlanta (Chapelle Davis, Assistant Vice President) 1000 Peachtree Street NE., Atlanta, Georgia 30309:

1. *Robertson Holding Company, L.P., and Unified Shares, LLC,* both of Harrogate, Tennessee, to acquire 100 percent of the outstanding shares of National Bank of Tennessee, Newport, Tennessee.

Board of Governors of the Federal Reserve System, March 2, 2016.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2016–05051 Filed 3–7–16; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Savings and Loan Holding Company

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and the Board's Regulation LL (12 CFR part 238) to acquire shares of a savings and loan holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than March 22, 2016.

A. Federal Reserve Bank of Atlanta (Chapelle Davis, Assistant Vice President) 1000 Peachtree Street NE., Atlanta, Georgia 30309:

1. *Peter William Hampton, Jr., Elizabethton, Tennessee, individually and as co-trustee of the Margaret Hampton Revocable Trust and the Peter W. Hampton Family and Marital Trust (The Trusts), and as custodian for William Spencer Hampton; and Harriette Lee Hampton, Ridgeland, Mississippi, individually and as co-trustee of The Trusts, and as power of attorney for Margaret Hampton, Elizabethton, Tennessee;* to acquire additional voting shares of SFB Bancorp and thereby indirectly acquire additional voting shares of Security Federal Bank, Elizabethton, Tennessee.

Board of Governors of the Federal Reserve System, 2016.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2016–05049 Filed 3–7–16; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Savings and Loan Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Home Owners' Loan Act (12 U.S.C. 1461 *et seq.*) (HOLA), Regulation LL (12 CFR part 238), and Regulation MM (12 CFR part 239), and all other applicable statutes and regulations to become a savings and loan holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a savings association and nonbanking companies owned by the savings and loan holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the HOLA (12 U.S.C. 1467a(e)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 10(c)(4)(B) of the HOLA (12 U.S.C. 1467a(c)(4)(B)). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than April 1, 2016.

A. Federal Reserve Bank of Dallas (Robert L. Triplett III, Senior Vice President) 2200 North Pearl Street, Dallas, Texas 75201–2272:

1. *The SLHC Trust,* Raleigh, North Carolina; to become a savings and loan holding company by acquiring at least 64 percent of the voting shares of NexBank Capital, Inc., and thereby indirectly acquire voting shares of NexBank, SSB, both in Dallas, Texas.

Board of Governors of the Federal Reserve System, March 3, 2016.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2016–05088 Filed 3–7–16; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket Number CDC–2016–0002; NIOSH–214]

Request for Information on NIOSH Center for Direct Reading and Sensor Technologies: Sensors for Emergency Response Activities; Extension of Comment Period

AGENCY: National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice and extension of comment period.

SUMMARY: On January 19, 2016, the Director of the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC), published a notice in the **Federal Register** [81 FR 2866] requesting information to enhance the value of the NIOSH Center for Direct Reading and Sensor Technologies entitled *Request for Information on NIOSH Center for Direct Reading and Sensor Technologies: Sensors for Emergency Response Activities.* Written comments were to be received by March 21, 2016. NIOSH is extending the public comment period until April 22, 2016.

DATES: NIOSH is extending the comment period on the document published January 21, 2016 (81 FR 2866). Electronic or written comments must be received by April 22, 2016.

ADDRESSES: You may submit comments, identified by CDC–2016–0002 and docket number NIOSH–214, by any of the following methods:

• *Federal eRulemaking Portal: www.regulations.gov* Follow the instructions for submitting comments.

• *Mail:* National Institute for Occupational Safety and Health, NIOSH Docket Office, 1090 Tusculum Avenue, MS C–34, Cincinnati, Ohio 45226–1998.

FOR FURTHER INFORMATION CONTACT: D. Gayle DeBord, NIOSH, Division of Applied Research and Technologies, Robert A. Taft Laboratories, 1090 Tusculum Avenue, MS–R2, Cincinnati, Ohio 45226, Phone: (513) 841–4256 [not a toll-free number], Email: *GDeBord@cdc.gov.*

Dated: February 26, 2016.

John Howard,

Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.

[FR Doc. 2016–04963 Filed 3–7–16; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Federal Tax Offset, Administrative Offset, and Passport Denial.

OMB No.: 0970–0161.

Description: The Federal Offset programs (Federal Tax Refund Offset and Administrative Offset) collect past-

due child and spousal support by intercepting certain Federal payments, including Federal tax refunds, of parents who have been ordered to pay support and are delinquent. The Federal Offset programs consist of a cooperative effort among the Department of the Treasury's Bureau of the Fiscal Service, the Federal Office of Child Support Enforcement (OCSE), and State child support agencies.

The Passport Denial program reports noncustodial parents who owe child and spousal support above a threshold to the Department of State, which will then deny passports.

On an ongoing basis, State child support agencies submit names, Social Security numbers, and the amount(s) of past-due child and spousal support of noncustodial parents who are delinquent in making payments to OCSE.

Federal laws authorize information collection activities pertaining to the Federal Offset and Passport Denial programs and require State child support agencies to submit information pertaining to past-due support that meets specific criteria and to comply with Annual Certification Letter requirements:

(1) 42 U.S.C. 652(b), 42 U.S.C. 664, and 26 U.S.C. 6402(c), for the offset of the Federal tax refund of the noncustodial parent;

(2) 31 U.S.C. 3701 *et seq.* and 31 U.S.C. 3716(h), for the offset of the Federal payments other than Federal tax refunds of the noncustodial parent; and

(3) 42 U.S.C. 654(31) and 42 U.S.C. 652(k), to Department of State for the denial, revocation, restriction, or limitation of the passport of the noncustodial parent.

Respondents: State IV–D Agencies.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Input Record	54	52	.3	842.40
Output Record	54	52	.46	1,291.68
Payment File	54	52	.135	379.08
Certification Letter	54	1	.4	21.60
CSP FCE Processing screens	173	280.65	0.01	485.52
Total				3,020.28

Estimated Total Annual Burden Hours: 3,020 hours.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 330 C Street SW., Washington, DC 20201. Attention Reports Clearance Officer. All requests should be identified by the title of the information collection. Email address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Email: *OIRA_SUBMISSION@OMB.EOP.GOV,* Attn: Desk Officer for the Administration for Children and Families.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2016–05077 Filed 3–7–16; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

National Child Care Hotline and Web Site; Comment Request

AGENCY: Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: As authorized by section 658L(b) of the Child Care and Development Block Grant (CCDBG) Act (42 U.S.C. 9858j(b)), as amended by the CCDBG Act of 2014 (Pub. L. 113–186), the Administration for Children and Families (ACF) is developing a National toll-free hotline and Web site for child care. We are interested in comments that describe effective design features and easy-to-use functions for a national Web site that will link to new and existing state and local Web sites. The Web site will disseminate easy-to-understand information about Child Care and Development Fund (CCDF) funded child care providers for parents of eligible children, the general public, and providers. The new national hotline will link to new and existing CCDF Lead Agency hotlines where users can report possible health and safety violations or instances of child abuse and neglect in CCDF-eligible provider settings.

ACF previously asked for comments and suggestions related to the national Web site for consumer education, submission of complaints and related provisions in the CCDBG Act in a Notice of Proposed Rulemaking (80 FR 80465, Dec. 24, 2015, available online at *https://federalregister.gov/a/2015-31883).* If you have already commented on this regulatory process, there is no need to duplicate your comments. However, if your comments are more closely related to the design, functionality, or other considerations of the national Web site or hotline, we invite your additional comments here.

DATES: The deadline for receipt of comments is midnight, April 7, 2016.

ADDRESSES: Submit comments to *NHWcomment@acf.hhs.gov.*

SUPPLEMENTARY INFORMATION:

The CCDBG Act of 2014

Two of the CCDBG Act's purposes are ''to promote parental choice to empower working parents to make their own decisions regarding the child care services that best suits their family's needs'' and ''to encourage States to provide consumer education information to help parents make informed choices about child care services and to promote involvement by parents and family members in the development of their children in child care settings'' (42 U.S.C. 9857(b)(1) & (3)). Subpart D of the proposed

regulations describes parental rights and responsibilities and provisions related to parental choice, including requirements that Lead Agencies maintain a record of parental complaints and consumer education activities conducted by Lead Agencies to increase parental awareness of the range of child care options available to them.

Lead Agency Consumer Education Web site

ACF has proposed amending paragraph (a) of § 98.33 to require Lead Agencies ''to collect and disseminate consumer education information to parents of eligible children, the general public, and providers through a consumer-friendly and easily accessible Web site'' (80 FR 80569–70) Consistent with new requirements enacted by the CCDBG Act of 2014, the proposed regulations would require state Web sites to, at a minimum, include five components: (1) Lead Agency policies and procedures, (2) provider-specific information, (3) aggregate number of deaths, serious injuries, and instances of substantiated child abuse in child care settings each year, (4) referral to local child care resource and referral organizations, and (5) directions on how parents can contact the Lead Agency, or its designee, and other programs to better understand information on the Web site.

The reauthorized CCDBG Act also requires the Secretary to operate, either directly or through the use of grants or contracts, a national Web site and a national toll free hotline. Both the national Web site and hotline must have the capacity to help families in every state and community in the nation.

National Consumer Education Web site

While the primary responsibility to operate a parental complaint hotline and a consumer education Web site remains with Lead Agencies, the CCDBG Act also requires the Secretary to operate a national Web site for consumer education and submission of complaints (42 U.S.C. 9858j(b)). The statute requires several components be included in the national Web site, including many of the same requirements of the Lead Agency consumer education Web sites. We propose to incorporate all requirements of the national Web site into the requirements of the Lead Agency consumer education Web site, including the localized list of child care providers searchable by zip code proposed at § 98.33(a)(2)(i) (80 FR 80570). The statute allows for the national Web site to provide the information either ''directly or through linkages to State databases'' (42 U.S.C. 9858j(b)(2)(b)). It is not feasible or practical for HHS to recreate databases many states have already created. Therefore, we are proposing to require Lead Agencies to include these components in their databases and Web sites to which we plan to link the national Web site.

ACF intends to design a national Web site that will respond to the CCDBG Act requirements and will connect to state, territory, and local systems, if available, provide an additional entry point to Lead Agency Web sites for families seeking information, and make that information available in multiple languages. The national Web site will not create a national database or duplicate Lead Agency systems already in place.

The national Web site will be hosted by 'childcare.gov' and refer users to local child care providers 24 hours a day. The Web site will provide easy-to-understand child care consumer education and referral services and enable a child care consumer to enter a zip code and obtain a referral to local child care providers within a specified search radius.

The national Web site will provide to consumers, directly or through linkages to state databases, at a minimum: a localized list of all eligible child care providers, differentiating between licensed and license-exempt providers; any provider-specific information from a Quality Rating and Improvement System or information about other quality indicators, any other provider-specific information about compliance with licensing and health and safety requirements to the extent the information is publicly available and to the extent practicable; referrals to local resource and referral organizations from which consumers can find more information about child care providers; and state information about child care subsidy programs and other financial supports available to families.

National Hotline

The primary purpose of the parental complaint hotline is to provide parents with an easy way to submit complaints about unmet health and safety regulations or child abuse and neglect by a child care provider or their staff.

The design for a national parental complaint hotline will also respond to the CCDBG Act requirements, be toll free, and connect to a Lead Agency single point of contact as an additional option for parents and the public. While not intended as a child care referral call center, the national hotline will provide links to applicable state information. It will not serve as a federal investigatory system.

The value of parental complaint hotlines is illustrated by the longstanding national hotline established for the Department of Defense (DOD) military child care program. The Military Child Care Act of 1989 (Pub. L. 101–189) required the creation of a national 24-hour, toll-free hotline that allows parents to submit complaints about military child care centers anonymously. DOD has found the hotline to be an important tool in engaging parents in child care. In addition, complaints received through the hotline have helped DOD identify problematic child care programs. (Campbell, N., Appelbaum, J., Martinson, K., Be All That We Can Be: Lessons from the Military for Improving Our Nation's Child Care System, National Women's Law Center, 2000).

Request for Comments

ACF recognizes the diversity of existing systems and processes, information technology (IT) systems' capacity, investments, and limited resources (time, people, funding) available to Lead Agencies and their partners. We are not only interested in comments that describe effective and easy-to-use design features for a national parent complaint hotline and a national consumer education Web site, but also in how the design of both can help Lead Agencies as they adapt their systems to implement federal guidance. We welcome all comments and suggestions around the functions and features for both the national Web site and the national parent complaint hotline and encourage your input around the following:

National Consumer Complaint Hotline

- The national parent complaint hotline will be available for parents and providers who want to report health and safety violations or child abuse in CCDBG-eligible child care. What will parents and providers need to make the hotline easy to find and use?
- What protocols should be included for use with a national hotline to make sure that local, state, or territory authorities follow up on any complaints reported to the national parent complaint hotline?
- What types of information will help states and territories increase their ability to receive and share data with a national hotline?
- When thinking about the implementation of a parent complaint hotline, what barriers, challenges, and concerns come to mind related to current state policy and laws that might

impact the ability of state and territory agencies and a national hotline to share information with each other?

National Consumer Education and Referral Web site

- The CCDBG Act of 2014 and proposed rules list the types of information that must be made available for parents and providers on a state, territory, and national Web site. What will parents and providers need to make this information useful when searching for high-quality early childhood services? In particular, what Web site design features will deliver information that is accurate and easy to find and understand, so that parents can easily find high-quality services that meet their needs? Are there any priorities?
- Providers may use the national Web site as a way to increase visibility of their programs and services. What kinds of information should providers be able to include that would help both themselves and parents?
- A primary tenant of the national Web site will be to link to Web sites, services, and data that state and territory lead agencies make available. To remove any overlap of services, what national Web site design options will support these efforts?
- When it comes to data availability, what national Web site supports will help existing state and local systems to participate in the national Web site? For example: would state and local systems benefit from guidance on how to develop effective web services, data governance, application programming interfaces (API), or creating standards for collection of data?
- With a focus on provider quality information and availability of data, what information or technical assistance will state and territories need to make this information available online?
- What technologies and strategies can be used to overcome barriers, challenges, and concerns regarding potential design models of a national Web site?

Dated: March 2, 2016.

Linda K. Smith,

Deputy Assistant Secretary for Early Childhood Development, Administration for Children and Families, U.S. Department of Health and Human Services.

[FR Doc. 2016–05085 Filed 3–7–16; 8:45 am]

BILLING CODE 4184–43–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: In compliance with section 3507(a)(1)(D) of the Paperwork Reduction Act of 1995, the Health Resources and Services Administration (HRSA) has submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period.

DATES: Comments on this ICR should be received no later than April 7, 2016.

ADDRESSES: Submit your comments, including the Information Collection Request Title, to the desk officer for HRSA, either by email to *OIRA_submission@omb.eop.gov,* or by fax to 202–395–5806.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email the HRSA Information Collection Clearance Officer at *paperwork@hrsa.gov,* or call (301) 443–1984.

SUPPLEMENTARY INFORMATION:

Information Collection Request Title: Telehealth Resource Center Performance Measurement Tool. OMB No. 0915–0361—Revision

Abstract: To ensure the best use of public funds and to meet the Government Performance Review Act requirements, the Federal Office of Rural Health's Office for the Advancement of Telehealth (OAT) in collaboration with the Telehealth Resource Centers (TRCs) created a set of performance measures that grantees can use to evaluate the technical assistance services provided by the TRCs. Grantee goals are to customize the provision of telehealth technical assistance across the country. The TRCs provide technical assistance to health care organizations, health care networks, and health care providers in the implementation of cost-effective telehealth programs to serve rural and medically underserved areas and populations.

Need and Proposed Use of the Information: The revised measures will be used to evaluate the effectiveness of the technical assistance. The tool will also be used to address GPRA requirements and to report to Congress the value added from the TRC Grant Program; justification for budget request; measure performance relative to the mission of OAT/HRSA, as well as individual goals and objectives of the program; identify topics of interest for future special studies; identify changes in healthcare needs within rural communities, allowing programs to shift focus in order to meet those needs; and collect uniform consistent data and provide guidance to grantees.

Likely Respondents: The likely respondents will be telehealth associations, telehealth providers, rural health providers, clinicians that deliver services via telehealth, technical assistance providers, research organizations, and academic medical centers.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Telehealth Resource Center Performance Data Collection	14	42	588	0.07	41.16
Total	14	42	588	0.07	41.16

Jackie Painter,

Director, Division of the Executive Secretariat.

[FR Doc. 2016–05070 Filed 3–7–16; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

''Low Income Levels'' Used for Various Health Professions and Nursing Programs Authorized in Titles III, VII, and VIII of the Public Health Service Act

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Health Resources and Services Administration (HRSA) is updating income levels used to identify a ''low income family'' for the purpose of determining eligibility for programs that provide health professions and nursing training to individuals from disadvantaged backgrounds. These various programs are authorized in Titles III, VII, and VIII of the Public Health Service Act.

The Department periodically publishes in the **Federal Register** low-income levels to be used by institutions receiving grants and cooperative agreements in order to determine eligibility for programs providing training for (1) disadvantaged individuals, (2) individuals from disadvantaged backgrounds, or (3) individuals from low-income families.

SUPPLEMENTARY INFORMATION: Many health professions and nursing grant and cooperative agreement awardees use the low-income levels to determine whether potential program participants are from an economically disadvantaged background and would be eligible to participate in the program, as well as to determine the amount of funding the individual receives. Federal agencies generally make awards to: Accredited schools of medicine, osteopathic medicine, public health, dentistry, veterinary medicine, optometry, pharmacy, allied health, podiatric medicine, nursing, and chiropractic; public or private nonprofit schools which offer graduate programs in behavioral health and mental health practice; and other public or private nonprofit health or education entities to assist the disadvantaged to enter and graduate from health professions and nursing schools. Some programs provide for the repayment of health professions or nursing education loans for disadvantaged students.

The Secretary defines a ''low-income family/household'' for programs included in Titles III, VII, and VIII of the Public Health Service Act as having an annual income that does not exceed 200 percent of the Department's poverty guidelines. A family is a group of two or more individuals related by birth, marriage, or adoption who live together. On June 26, 2013, in *U.S.* v. *Windsor,* 133 S. Ct. 2675 (2013), the Supreme Court held that section 3 of the Defense of Marriage Act, which prohibited federal recognition of same-sex spouses and same-sex marriages, was unconstitutional. In light of this decision, please note that in determining eligibility for these programs, same-sex marriages and same-sex spouses will be recognized on equal terms with opposite-sex marriages and opposite-sex spouses, regardless of where the couple resides. This approach is consistent with a post-Windsor policy of treating same-sex marriages on the same terms as opposite sex marriages to the greatest extent reasonably possible. Thus, a ''family or household'' includes same-sex spouses that are legally married in a jurisdiction that recognizes same-sex marriage regardless of whether the same-sex spouses live in a jurisdiction that recognizes same-sex marriage or a jurisdiction that does not recognize same-sex marriage as well as the family members that result from such same-sex marriage.

Most HRSA programs use the income of a student's parents to compute low income status. However, a ''household'' may potentially be only one person. Other HRSA programs, depending upon the legislative intent of the program, the programmatic purpose related to income level, as well as the age and circumstances of the participant, will apply these low income standards to the individual student to determine eligibility, as long as he or she is not listed as a dependent on the tax form of his or her parent(s). Each program announces the rationale and choice of methodology for determining low income levels in program guidance.

The Secretary annually adjusts the low-income levels based on the Department's poverty guidelines and makes them available to persons responsible for administering the applicable programs. The Department's poverty guidelines are based on poverty thresholds published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index. The income figures below have been updated to reflect the Department's 2016 poverty guidelines as published in 81 FR 15 (January 25, 2016).

LOW INCOME LEVELS BASED ON THE 2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household *	Income level **
1	$23,760
2	32,040
3	40,320
4	48,600
5	56,880
6	65,160
7	73,460
8	81,780

For families with more than 8 persons, add $8,320 for each additional person. * Includes only dependents listed on federal income tax forms. ** Adjusted gross income for calendar year 2015.

LOW INCOME LEVELS BASED ON THE 2016 POVERTY GUIDELINES FOR ALASKA

Persons in family/household *	Income level **
1	$29,680
2	40,040
3	50,400
4	60,760
5	71,120
6	81,480

LOW INCOME LEVELS BASED ON THE 2016 POVERTY GUIDELINES FOR ALASKA—Continued

Persons in family/household *	Income level **
7	91,840
8	102,240

For families with more than 8 persons, add $10,400 for each additional person. * Includes only dependents listed on federal income tax forms. ** Adjusted gross income for calendar year 2015.

LOW INCOME LEVELS BASED ON THE 2016 POVERTY GUIDELINES FOR HAWAII

Persons in family/household *	Income level **
1	$27,340
2	36,860
3	46,380
4	55,900
5	65,420
6	74,940
7	84,460
8	94,020

For families with more than 8 persons, add $9,560 for each additional person. * Includes only dependents listed on federal income tax forms. ** Adjusted gross income for calendar year 2015.

Separate poverty guidelines figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. Puerto Rico or other outlying jurisdictions shall use income guidelines for the 48 Contiguous States and the District of Columbia.

Dated: March 1, 2016.

James Macrae,

Acting Administrator.

[FR Doc. 2016–05084 Filed 3–7–16; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Minority Health and Health Disparities Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable materials, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Minority Health and Health Disparities Special Emphasis Panel, Behavioral Interventions to Prevent HIV in Diverse Adolescent Men Who Have Sex with Men (U01).

Date: April 4, 2016.

Time: 9:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892 (Telephone Conference Call)

Contact Person: Deborah Ismond, Ph.D., Scientific Review Officer, Division of Scientific Programs, National Institute on Minority Health and Health Disparities, National Institutes of Health, 6707 Democracy Blvd., Suite 800, Bethesda, MD 20892, (301) 402–1366, *ismonddr@mail.nih.gov.*

Dated: March 2, 2016.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05023 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Minority Health and Health Disparities; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable materials, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Minority Health and Health Disparities Special Emphasis Panel, NIMHD Transdisciplinary Collaborative Centers for Health Disparities Research on Chronic Disease Prevention (U54).

Date: April 5–April 6, 2016.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton Washington/Rockville, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: Maryline Laude-Sharp, Ph.D., Scientific Review Officer, National Institute on Minority Health and Health Disparities, National Institutes of Health, 6707 Democracy Blvd., Suite 800, Bethesda, MD 20892, (301) 451–9536, *mlaudesharp@mail.nih.gov.*

Dated: March 2, 2016.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05024 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Arthritis and Musculoskeletal and Skin Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel, NIAMS AMSC Clinical Trials Conflict Review Meeting.

Date: March 25, 2016.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: NIAMS Conference Room 803, 6701 Democracy Boulevard, Bethesda, MD 20892, (Teleconference).

Contact Person: Helen Lin, Ph.D., Scientific Review Officer, Scientific Review Branch, National Institute of Arthritis, Musculoskeletal and Skin Diseases, NIH, 6701 Democracy Boulevard, Suite 800, Bethesda, MD 20892, 301–594–4952, *linh1@mail.nih.gov.*

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin

Diseases Special Emphasis Panel, Rheumatic Disease Core Center (P30) Review Panel.

Date: March 30–31, 2016.

Time: 7:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton Washington DC/Rockville, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: Yin Liu, Ph.D., M.D., Scientific Review Officer, Scientific Review Branch, National Institute of Arthritis, and Musculoskeletal and Skin Diseases, National Institute of Health, Bethesda, MD 20892, 301–496–0505, *liuy@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.846, Arthritis, Musculoskeletal and Skin Diseases Research, National Institutes of Health, HHS)

Dated: March 2, 2016.

Sylvia L. Neal,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05022 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Pregnancy, Weight Loss and Energy Balance.

Date: March 28, 2016.

Time: 12:00 p.m. to 1:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Dianne Hardy, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 6175, MSC 7892, Bethesda, MD 20892, 301–435–1154, *dianne.hardy@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: AIDS and AIDS Related Research.

Date: March 30–31, 2016.

Time: 9:00 a.m. to 12:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Kenneth A Roebuck, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5106, MSC 7852, Bethesda, MD 20892, (301) 435–1166, *roebuckk@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; RFA–RM–15–008: Novel and Innovative Tools to Facilitate Identification, Tracking, Manipulation, and Analysis of Glycans and their Functions (R21).

Date: March 30–31, 2016.

Time: 9:30 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892.

Contact Person: Vonda K Smith, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 6188, MSC 7892, Bethesda, MD 20892, 301–435–1789, *smithvo@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Non-HIV Diagnostics, Food Safety, Sterilization/Disinfection and Bioremediation.

Date: March 31–April 1, 2016.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Residence Inn Bethesda, 7335 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Gagan Pandya, Ph.D., Scientific Review Officer, National Institutes of Health, Center for Scientific Review, 6701 Rockledge Drive, RM 3200, MSC 7808, Bethesda, MD 20892, 301–435–1167, *pandyaga@mail.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Biological Chemistry and Macromolecular Biophysics.

Date: March 31–April 1, 2016.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Virtual Meeting)

Contact Person: David R Jollie, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4150, MSC 7806, Bethesda, MD 20892, (301)–435–1722, *jollieda@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR16–027: Commercialization Readiness Pilot.

Date: April 1, 2016.

Time: 10:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892.

Contact Person: Cristina Backman, Ph.D., Scientific Review Officer, ETTN IRG, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5211, MSC 7846, Bethesda, MD 20892, *cbackman@mail.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Synthesis of Glycans and Glycoproteins.

Date: April 1, 2016.

Time: 2:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: C-L Albert Wang, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4146, MSC 7806, Bethesda, MD 20892, 301–435–1016, *wangca@csr.nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; RFA–RM–15–007: Facile Methods and Technologies for Synthesis of Biomedically Relevant Carbohydrates.

Date: April 1, 2016.

Time: 12:00 p.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892.

Contact Person: William A Greenberg, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4168, MSC 7806, Bethesda, MD 20892, (301) 435–1726, *greenbergwa@csr.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: March 2, 2016.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05017 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center For Scientific Review; Cancellation of Meeting

Notice is hereby given of the cancellation of the Center for Scientific Review Special Emphasis Panel, March 24, 2016, 2:30 p.m. to March 24, 2016, 5:00 p.m., National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 which was published in the **Federal Register** on February 29, 2016, 81 FR 10264.

The meeting is cancelled due to the reassignment of applications.

Dated: March 2, 2016.

Natasha M. Copeland,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05020 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Proposed Collection; 60-Day Comment Request; Survey To Assess the Feasibility of Establishing a Gynecologic Specimen Bank (NCI)

SUMMARY: In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, for opportunity for public comment on proposed data collection projects, the National Cancer Institute, the National Institutes of Health (NIH) will publish periodic summaries of proposed projects to be submitted to the Office of Management and Budget (OMB) for review and approval.

Written comments and/or suggestions from the public and affected agencies are invited to address one or more of the following points: (1) Whether the proposed collection of information is necessary for the proper performance of the function of the agency, including whether the information will have practical utility; (2) The accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) The quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

TO SUBMIT COMMENTS AND FOR FURTHER INFORMATION: To obtain a copy of the data collection plans and instruments, submit comments in writing, or request more information on the proposed project, contact: Goli Samimi, Program Director, Breast and Gynecologic Cancer Research Group, Division of Cancer Prevention, 9609 Medical Center Drive, MSC 9783, Bethesda, MD 20892, or call non-toll-free number (240) 276–6582, or Email your request, including your address to: *goli.samimi@nih.gov.* Formal requests for additional plans and instruments must be requested in writing.

Comment Due Date: Comments regarding this information collection are best assured of having their full effect if received within 60 days of the date of this publication.

Proposed Collection: Survey to assess the feasibility of establishing a gynecologic specimen bank (NCI), 0925–NEW, National Cancer Institute (NCI), National Institutes of Health (NIH).

Need and Use of Information Collection: The National Cancer Institute is assessing the feasibility of developing a tissue bank that would include tube and ovary tissues from women undergoing surgery for benign conditions, risk reduction and early stage cancer. Collecting tissues from tubes and ovaries containing clinically unsuspected precursors or early stage cancer is challenging, especially among women that are not at increased genetic risk. However, given that many pathology laboratories have enhanced their processing protocols for gynecologic surgical specimens removed for benign indications, it may be possible to develop a tissue resource. Accordingly, we are requesting information via a survey about the volume of samples that are accessioned at different pathology laboratories, and the methods used to process these samples. These data would provide information necessary to assess the feasibility of establishing a tissue bank for research and provide insights into the best design of a pilot study.

OMB approval is requested for 1 year. There are no costs to respondents other than their time. The total estimated annualized burden hours are 42 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Category of respondent	Form name	Number of respondents	Frequency of response per respondent	Time per response (in hours)	Burden hours
Lab Managers	Survey.	250	1	10/60	42
Totals		250			42

Dated: March 2, 2016.

Karla Bailey,

Project Clearance Liaison, National Cancer Institute, NIH.

[FR Doc. 2016–05021 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Cancer Institute Board of Scientific Advisors, March 29, 2016, 08:30 a.m. to March 30, 2016, 12:00 p.m., National Institutes of Health, 31 Center Drive, Building 31, Conference Room 10, Bethesda, MD, 20892 which was published in the **Federal Register** on February 26, 2016, 81 FR 9867.

The meeting notice is amended to change the meeting date to March 29, 2016. The meeting is open to the public.

Dated: March 2, 2016.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05018 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material,

and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Special Emphasis Panel, NCI Omnibus R03 & R21 SEP–13.

Date: April 6–7, 2016.

Time: 8:00 a.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Residence Inn Bethesda, 7335 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Jeffrey E. DeClue, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, 7W114, Bethesda, MD 20892–8329, 240–276–6371, *decluej@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, NCI Omnibus R03 & R21 SEP–5.

Date: April 14–15, 2016.

Time: 8:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Gaithersburg Marriott Washingtonian Center, 9751 Washingtonian Boulevard, Bethesda, MD 20878.

Contact Person: Thomas A. Winters, Ph.D., Scientific Review Officer, Special Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, 7W412, Bethesda, MD 20892–9750, 240–276–6386, *twinters@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis, Panel NCI Omnibus R03 & R21 SEP–17.

Date: April 14, 2016.

Time: 11:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute Shady Grove, 9609 Medical Center Drive, Room 2W030, Rockville, MD 20890, (Telephone Conference Call).

Contact Person: Gerard Lacourciere, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W248, Bethesda, MD 20892–9750, 240–276–5457, *gerald.lacourciere@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, NCI Omnibus SEP–18.

Date: April 14, 2016.

Time: 1:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute Shady Grove, 9609 Medical Center Drive, Room 7W104, Rockville, MD 20850, (Telephone Conference Call).

Contact Person: Eun Ah Cho, Ph.D., Scientific Review Officer, Special Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W104, Bethesda, MD 20892–9750, 240–276–6342, *choe@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, NCI Omnibus SEP–19.

Date: April 15, 2016.

Time: 10:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute Shady Grove, 9609 Medical Center Drive, Room 7W030, Rockville, MD 20890, (Telephone Conference Call).

Contact Person: Clifford W. Schweinfest, Ph.D., Scientific Review Officer, Special Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, 7W108, Bethesda, MD 20892–9750, 240–276–6343, *schweinfestcw@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, Collaborative Research in Integrative Cancer Biology.

Date: April 19, 2016.

Time: 11:00 a.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute Shady Grove, 9609 Medical Center Drive, Room 4W030, Rockville, MD 20850, (Telephone Conference Call).

Contact Person: Gerard Lacourciere, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W248, Rockville, MD 20850, 240–276–5458, *gerard.lacourciere@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: March 2, 2016.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2016–05019 Filed 3–7–16; 8:45 am]

BILLING CODE 4140–01–P

ADVISORY COUNCIL ON HISTORIC PRESERVATION

Notice of Advisory Council on Historic Preservation Quarterly Business Meeting

AGENCY: Advisory Council on Historic Preservation.

ACTION: Notice of Advisory Council on Historic Preservation Quarterly Business Meeting.

SUMMARY: Notice is hereby given that the Advisory Council on Historic Preservation (ACHP) will hold its next quarterly meeting on Thursday, March 24, 2016. The meeting will be held at the Westin Tampa Harbour Island Hotel at 725 South Harbour Island Boulevard, Tampa, Florida, starting at 10:30 a.m.

DATES: The quarterly meeting will take place on Thursday, March 24, 2016, starting at 10:30 a.m.

ADDRESSES: The meeting will be held the Westin Tampa Harbour Island Hotel at 725 South Harbour Island Boulevard, Tampa, Florida.

FOR FURTHER INFORMATION CONTACT: Cindy Bienvenue, 202–517–0202, *cbienvenue@achp.gov.*

SUPPLEMENTARY INFORMATION: The Advisory Council on Historic Preservation (ACHP) is an independent federal agency that promotes the preservation, enhancement, and sustainable use of our nation's diverse historic resources, and advises the President and the Congress on national historic preservation policy. The goal of the National Historic Preservation Act (NHPA), which established the ACHP in 1966, is to have federal agencies act as responsible stewards of our nation's resources when their actions affect historic properties. The ACHP is the only entity with the legal responsibility to encourage federal agencies to factor historic preservation into federal project requirements. For more information on the ACHP, please visit our Web site at *www.achp.gov.*

The agenda for the upcoming quarterly meeting of the ACHP is the following:

I. Chairman's Welcome
II. Historic Preservation Policy and Programs
  A. Building a More Inclusive Preservation Program
  1. American Latino Heritage Initiative
  2. ACHP Youth Initiatives
  B. Preservation50 and the ACHP Public Policy Initiative
  C. Policy Statement for Resilient Communities
  D. White House Council on Climate Preparedness and Resilience
  E. Historic Preservation Legislation in the 114th Congress
  1. Historic Preservation Fund Reauthorization
  2. Historically Black Colleges and Universities Reauthorization
  3. African American Civil Rights Network legislation
  4. Preservation Research at Institutions Serving Minorities (PRISM) Act
  5. Native American Tourism and Improving Visitor Experience (NATIVE) Act
III. Section 106 Issues
  A. Federal Agency Support for SHPOs and THPOs
  B. Public Involvement in the Section

106 Process
C. Fixing America's Surface Transportation (FAST) Act
IV. ACHP Native American Affairs Committee Activities
V. New Business
VI. Adjourn

The meetings of the ACHP are open to the public. If you need special accommodations due to a disability, please contact Cindy Bienvenue, 202–517–0202 or *cbienvenue@achp.gov,* at least seven (7) days prior to the meeting.

Authority: 54 U.S.C. 304102

Dated: March 3, 2016.

Javier E. Marques,

Associate General Counsel.

[FR Doc. 2016–05154 Filed 3–7–16; 8:45 am]

BILLING CODE 4310–K6–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–R2–ES–2015–N192; FXES11120200000–167–FF02ENEH00]

Notice of Availability: Environmental Assessment and Draft Amended Oil and Gas Industry Conservation Plan for the American Burying Beetle in Oklahoma

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of availability of documents; request for public comment.

SUMMARY: We, the U.S. Fish and Wildlife Service, announce the availability of an environmental assessment (EA), under the National Environmental Policy Act of 1969, that evaluates the impacts of a draft amendment to the Oil and Gas Industry Conservation Plan (ICP) for incidental take of the federally listed American burying beetle resulting from oil and gas industry activities. The original ICP (2014 ICP) was approved on May 21, 2014. The proposed amendment to the ICP will extend by 3 years the periods for signup, submission of individual project plans (IPPs), project construction, and ICP/permit duration. It also will provide date-certain deadlines, which will reduce confusion and simplify tracking for both permittees and the Service. In addition, we propose to delete language that limits coverage to projects that are fully contained within the ICP planning area. There is no change to the covered species, total amount of take authorized, or the planning area, which consists of 45 counties in Oklahoma. Individual oil and gas companies would continue to apply for Endangered Species Act permits for incidental take and agree to comply with the terms and conditions of the ICP.

DATES: To ensure consideration, written comments must be received or postmarked on or before April 7, 2016. Any comments we receive after the closing date or not postmarked by the closing date may not be considered in the final decision on this action.

ADDRESSES: *Obtaining Documents:*

- *Internet:* You may obtain copies of the EA and draft amendment to the ICP on the U.S. Fish and Wildlife Service's (Service) Web site at *www.fws.gov/southwest/es/oklahoma/ABBICP.*
- *U.S. Mail:* A limited number of CD–ROM and printed copies of the EA and draft amendment to the ICP are available, by request, from the Field Supervisor, by mail at the Oklahoma Ecological Services Field Office, 9014 E. 21st St., Tulsa, OK 74129; by phone at 918–581–7458; or by fax at 918–581–7467. Please note that your request is in reference to the draft amended ICP for American burying beetle in Oklahoma.
- *In-Person:* Copies of the EA and draft amended ICP are also available for public inspection and review at the following locations, by appointment and written request only, 8 a.m. to 4:30 p.m.:
  - U.S. Fish and Wildlife Service, 500 Gold Avenue SW., Room 6034, Albuquerque, NM 87102.
  - U.S. Fish and Wildlife Service, 9014 E. 21st St., Tulsa, OK 74129.

Comment submission: You may submit comments by one of the following methods.

- *U.S. Mail:* U.S. Fish and Wildlife Service, Oklahoma Ecological Services Field Office, 9014 E. 21st St., Tulsa, OK 74129; by phone at 918–581–7458; or by fax at 918–581–7467.
- *Electronically: fw2_hcp_permits@fws.gov.*

FOR FURTHER INFORMATION CONTACT: Jonna Polk, Field Supervisor, by U.S. mail at the U.S. Fish and Wildlife Service, Oklahoma Ecological Services Field Office, 9014 E. 21st St., Tulsa, OK 74129; or by phone at 918–581–7458.

SUPPLEMENTARY INFORMATION: Under the National Environmental Policy Act of 1969 (NEPA; 42 U.S.C. 4321 *et seq.*), this notice advises the public that we, the Service, have gathered the information necessary to determine impacts of the EA and draft amendment to the ICP related to the proposed issuance of incidental take permits (ITPs) under section 10(a)(1)(B) of the Endangered Species Act of 1973, as amended (ESA), to oil and gas companies (applicants) who agree to the conditions in the draft amended ICP. The ICP is a habitat conservation plan (HCP) that covers take of the American burying beetle (ABB) in Oklahoma that is incidental to covered activities associated with geophysical exploration (seismic), development, extraction, or transport of crude oil, natural gas, and/or other petroleum products, as well as maintenance, operation, repair, and decommissioning of oil and gas pipelines and well field infrastructure, and will include measures necessary to minimize and mitigate impacts to the covered species and its habitat to the maximum extent practicable.

The Service plans to amend the ICP to cover several changes. We plan to (1) extend the timeframe for oil and gas companies (industry) to apply for participation in the ICP; (2) extend the expiration date of the ICP and permits by 3 years; (3) extend the construction period to 3 years after permit issuance and approval of individual project plans (IPP); (4) extend operations and management coverage to the permit expiration date; (5) provide date-certain limits for each period to help industry and the Service simplify record-keeping; and (6) remove requirements that all projects must be completely within the planning area. Removing the restriction will expand the type of activities to include pipelines from other areas.

Under the proposed amendment there are no proposed changes to the federally listed species. The American burying beetle (ABB) is the only species covered for incidental take in the draft amended ICP, and the total amount of take has not been increased. There are no changes to the process for applying for an incidental take permit or submission of individual project plans (IPPs), other than the removal of the requirement for the project to be entirely contained within the covered area. There are no changes to the covered area, which consists of the following 45 Oklahoma counties: Adair, Atoka, Bryan, Carter, Cherokee, Choctaw, Cleveland, Coal, Craig, Creek, Delaware, Garvin, Haskell, Hughes, Johnson, Kay, Latimer, Le Flore, Lincoln, Love, Marshall, Mayes, McClain, McCurtain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Rogers, Seminole, Sequoyah, Tulsa, Wagoner, and Washington.

The 2014 ICP allows industry to apply for a permit to participate for the first two years from the date of approval and signature—May 21, 2014. Construction is allowed for the first 2 years, and operations and maintenance for up to an additional 20 years. The estimates of potential impacts from industry activities for the ICP were based on

recent history of development at the time of development and industry predictions. However, industry activity and impacts have been less than expected due to reduced petroleum prices and market conditions, and the amount of take issued under the 2014 ICP has been significantly lower than anticipated (32,234 acres allowed, with only 395 acres approved as of January 11, 2016). The 2014 ICP is only open for new applications through May 21, 2016, and incidental take authorized through the ICP is unlikely to approach the 32,234 acres allowed by that date.

The amendment will extend by 3 years the period for ICP signup, submission of IPPs, and construction after IPP approval. All applications under the amended ICP must be received by May 20, 2019, but may be approved after that date. Once approved and permitted, the permit holder must still submit their IPPs for approval by the Oklahoma Ecological Services Office prior to construction under the permit. Under the amended plan, IPPs must be received by May 20, 2022, and all construction related to IPPs must be completed by May 20, 2025. Operation and maintenance activities are authorized until the permit expires on May 20, 2039. Therefore, incidental take issued under this ICP may occur across a maximum of 25 years. All incidental take coverage provided by the amended ICP will end when the ICP and permits expire on May 20, 2039, regardless of when the individual permits or IPP applications were approved. Providing date-certain limits for each period will reduce confusion and simplify tracking for both permittees and the Service.

We also propose to remove all language that limits coverage to projects that are fully contained within the ICP planning area. Projects that extend beyond the planning area can apply for coverage for the portion that is within the planning area. This is with the understanding that the amended ICP will not provide any Endangered Species Act coverage or National Environmental Policy Act analysis for the portions of the projects that are outside the planning area. The change in timelines and allowing coverage for projects that are not fully contained within the ICP planning area are the only revisions to the ICP and EA. There are no changes to the biological opinion (BO).

We have assessed the potential impacts of the amendment to the ICP and reviewed the associated environmental assessment (EA) and BO for industry-related activities within the eastern Oklahoma planning area. Extending the same level of take over additional years is expected to reduce potential impacts to local habitat and ABB populations. Much of the oil and gas related impacts are temporary and can be restored within 2–5 years. Spreading the impacts over up to 11 years would allow temporary soil disturbance initiated in the first few years to be partially or fully restored before impacts from later projects have begun. The ABB is an annual species, and reducing take in any year should allow more adult beetles to survive into the next year. Incidental take authorized through the extension would not be increased, is a very small percentage of the total ABB habitat, and would not change the BO determination that the take would not jeopardize the continued existence of the ABB.

Permittees with existing ICP permits are bound by the terms and conditions of their existing permits. If they want the extended timeframes or reduced restrictions regarding being completely contained within the ICP Planning Area, they must apply for an amendment to their permit.

Background

Potential impacts as a result of the extension are not expected to increase beyond those already identified in the EA. Environmental consequences were reviewed for the ICP extension and potential impacts to the following resources were evaluated: Geology, Soils, Water Resources, Water Quality, Air Quality, Vegetation, Wetlands, General Wildlife, Threatened and Endangered Species, Land Use, Aesthetics and Noise, Socioeconomics, Environmental Justice, Tribal jurisdiction, and Cultural Resources. Minor benefits in the areas of Water Resources, Water Quality, Air Quality, Vegetation, Wetlands, General Wildlife, Threatened and Endangered Species, Land Use, Aesthetics, and Noise could occur, because any impacts of oil and gas construction activity would be spread out over up to 11 years. Local impacts of project-related soil disturbance such as removal of vegetation, erosion, and dust may be reduced, and some recovery of natural resources could be expected if spread out over additional years.

The ICP extension is not expected to significantly affect oil and gas activity, but would help support industry activity by streamlining compliance with the ESA, while continuing conservation efforts for the ABB. The 3-year ICP extension is not expected to trigger any new environmental consequences, or any new impacts to local economies or cultural resources. Nor are there any expected changes to direct, indirect, and cumulative effects. The ICP extension would not authorize any additional activities or incidental take. The same types and quantities of activities previously described in the EA are expected to occur with the 3-year extension. Based on the 2014 ICP, construction-related impacts could occur for up to 11 years (5 years from permit issuance, up to 3 additional years for IPP approval, and up to 3 years from IPP approval for construction) instead of for the original 2-year timeframe, and operation and maintenance-related impacts would occur over 25 years instead of the original 22 years.

Public Availability of Comments

Written comments we receive become part of the public record associated with this action. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can request in your comment that we withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so. We will not consider anonymous comments. All submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, will be made available for public disclosure in their entirety.

Authority

We provide this notice under section 10(c) of the ESA (16 U.S.C. 1531 *et seq.*) and its implementing regulations (50 CFR 17.22) and NEPA (42 U.S.C. 4321 *et seq.*) and its implementing regulations (40 CFR 1506.6).

Dated: February 2, 2016.

Benjamin N. Tuggle,

Regional Director, Southwest Region, Albuquerque, New Mexico.

[FR Doc. 2016–05086 Filed 3–7–16; 8:45 am]

BILLING CODE 4333–15–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–R2–ES–2015–N044]; [FXES11130200000–167–FF02ENEH00]

Endangered and Threatened Wildlife and Plants; Draft Recovery Plan for *Lilaeopsis schaffneriana* ssp. *recurva* (Huachuca Water Umbel)

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of availability; request for comment.

SUMMARY: We, the Fish and Wildlife Service (Service), announce the availability of our draft recovery plan for the *Lilaeopsis schaffneriana* ssp. *recurva* (Huachuca water umbel), which is listed as endangered under the Endangered Species Act of 1973, as amended (Act). This plant species is currently found in southern Arizona and in northern Sonora, Mexico. The draft recovery plan includes specific recovery objectives and criteria to be met in order to enable us to remove this species from the list of endangered and threatened wildlife and plants. We request review and comment on this plan from local, State, and Federal agencies; Tribes; and the public. We will also accept any new information on the status of the species throughout its range to assist in finalizing the recovery plan.

DATES: To ensure consideration, we must receive written comments on or before May 9, 2016. However, we will accept information about any species at any time.

ADDRESSES: *Obtaining Documents:* If you wish to review the draft recovery plan, you may obtain a copy by any one of the following methods:

Internet: Download the file at *www.fws.gov/southwest/es/Documents/R2ES/LilaeopsisSchaffneriana Recurva_DraftRecoveryPlan_Final_November2015.pdf;*

U.S. mail: Request a copy by writing to the Arizona Ecological Services Field Office, Fish and Wildlife Service, 2321 W. Royal Palm Road, Suite 103, Phoenix, AZ 85021; or

Telephone: Request a copy by calling (602) 242–0210.

Submitting Comments: If you wish to comment on the draft recovery plan, you may submit your comments in writing by any one of the following methods:

U.S. mail: Field Supervisor, at the above address;

Hand-delivery: Arizona Ecological Services Office, at the above address;

Fax: (602) 242–2513; or

Email: julie_crawford@fws.gov.

For additional information about submitting comments, see the ''Request for Public Comments'' section below.

FOR FURTHER INFORMATION CONTACT: Steve Spangle, Field Supervisor, U.S. Fish and Wildlife Service, Arizona Ecological Services Field Office, 2321 West Royal Palm Road, Suite 103, Phoenix, AZ 85021; telephone: 602–242–0210; facsimile: 602–242–2513. Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 800–877–8339.

SUPPLEMENTARY INFORMATION: We announce the availability of our draft recovery plan for the *Lilaeopsis schaffneriana* ssp. *recurva* (Huachuca water umbel), an endangered plant species currently found in southern Arizona and in northern Sonora, Mexico. The draft recovery plan includes specific recovery objectives and criteria to be met in order to enable us to remove this species from the list of endangered and threatened wildlife and plants. We request review and comment on this plan from local, State, and Federal agencies; Tribes; and the public. We will also accept any new information on the status of the species throughout its range to assist in finalizing the recovery plan.

Background

Recovery of endangered or threatened animals and plants to the point where they are again secure, self-sustaining members of their ecosystems is a primary goal of our endangered species program and the Act (16 U.S.C. 1531 *et seq.*). Recovery means improvement of the status of listed species to the point at which listing is no longer appropriate under the criteria set out in section 4(a)(1) of the Act. The Act requires the development of recovery plans for listed species, unless such a plan would not promote the conservation of a particular species.

Species History

Lilaeopsis schaffneriana ssp. *recurva* (Huachuca water umbel), found in aquatic habitats such as cienegas, rivers, streams, and springs of southern Arizona and northern Sonora, Mexico, was federally listed as endangered on January 6, 1997. On July 12, 1999, 83.2 kilometers (51.7 miles) of streams or rivers in Cochise and Santa Cruz Counties, Arizona, were designated as critical habitat. The taxon has been found historically in Cochise, Pinal, Pima, and Santa Cruz Counties, Arizona, and northern Sonora, Mexico. *Lilaeopsis schaffneriana* ssp. *recurva* is not listed under Mexican protected species regulations by the Secretaría de Medio Ambiente y Recursos Naturales. The recovery priority number for *L. schaffneriana* ssp. *recurva* is 3C, meaning that the listed entity is a subspecies, the level of threat is high, the potential for recovery is high, and there is a conflict with some form of economic activity (groundwater withdrawal for mining, agriculture, Fort Huachuca, municipal use, and private wells). The first 5-year status review for *L. schaffneriana* ssp. *recurva* was signed on August 21, 2014. Based on the static or declining status of the species across its range and continued threats, it was recommended in the 5-year review that the taxon remain listed as endangered.

Lilaeopsis schaffneriana ssp. *recurva* is a semi-aquatic to fully aquatic herbaceous perennial that ranges from 2.5 to 33 centimeters (cm) (0.98 to 12.99 inches (in)) depending on habitat. The leaves are round or elliptical in cross section, 0.5 to 5.5 millimeters (mm) (0.02 to 0.2 in) in diameter, and contain 6 to18 distinctive septa (thin partitions) along their length. Umbels (umbrella-like flower structures) develop on stalks shorter than the leaves, and contain three to ten 1.0 to 2.0 mm (0.04 to 0.08 in) wide perfect (containing male and female parts) flowers with five white to slightly maroon tinted petals and maroon anthers. Flowering has been observed episodically from March through October, peaking in July. The taxon reproduces both sexually via seed and asexually through rhizome spread and fragmentation. Clonal establishment following flooding events is thought to be important for maintaining diversity in the taxon; the seedbank can allow for recolonization following drought if hydric conditions return.

Groundwater pumping, regional drought, and climate change are among the largest threats to this taxon, which depends on the availability of permanently wet (or nearly so), muddy, or silty substrates with some organic content. At this time, the most significant long-term threats to the continued existence of the species are: (1) Aquatic habitat degradation; (2) the effects of drought and climate change; (3) wildfire and resulting sedimentation and scouring; (4) invasive non-native plant competition; and (5) livestock grazing. While propagation has proven successful, augmentation into new and previously occupied habitat has had mixed success. A larger challenge involves restoring appropriate habitat for the taxon, including the availability of perennial water.

The majority of critical habitat is under Federal administration through

the Coronado National Forest (National Forest Service), the San Pedro Riparian National Conservation Area (Bureau of Land Management), and Fort Huachuca Military Reservation (United States Army); a small portion is in private ownership. The taxon occurs in five watersheds in southeastern Arizona and adjacent portions of Sonora, Mexico. In the United States, we are aware of 17 locations supporting extant occurrences of *L. schaffneriana* ssp. *recurva,* 8 locations where all *L. schaffneriana* ssp. *recurva* occurrences are considered extirpated, and 6 locations where no occurrences have been relocated in recent years. In Sonora, Mexico, we are aware of 21 locations supporting *L. schaffneriana* ssp. *recurva* occurrences, though most of these locations have not been revisited in recent years. It is difficult to estimate the number of individuals due to the clonal nature of the taxon, though estimates of density indicate most occurrences are stable or in decline.

The principal recovery strategy is to conserve the habitat of *L. schaffneriana* ssp. *recurva* by implementing a variety of protection strategies, including decreasing groundwater pumping, increasing water conservation and recharge, and protecting *L. schaffneriana* ssp. *recurva* occurrences and their seedbanks. Providing conservation and restoration of the taxon and its habitat will allow stable, self-sustaining occurrences to persist with some level of connectivity and opportunities for expansion and dispersal. Additional efforts will focus on improving the baseline understanding of *L. schaffneriana* ssp. *recurva* ecology and threats.

Recovery Plan Goals

The objective of a recovery plan is to provide a framework for the recovery of a species so that protection under the Act is no longer necessary. A recovery plan includes scientific information about the species and provides criteria and actions necessary for us to be able to reclassify the species to threatened status or remove it from the list of federally endangered and threatened wildlife and plants. Recovery plans help guide our recovery efforts by describing actions we consider necessary for the species' conservation, and by estimating time and costs for implementing needed recovery measures. To achieve its goals, this draft recovery plan identifies the following objectives:

(1) Protect and restore functional aquatic habitat and reduce dewatering threats to known and newly discovered *L. schaffneriana* ssp. *recurva* occurrences and habitat.

(2) Conserve existing and newly discovered *L. schaffneriana* ssp. *recurva* occurrences and their seedbanks; establish new occurrences in appropriate habitat; establish plants at botanical gardens for research, recovery, and educational purposes; and maintain seeds for conservation and recovery at seed storage facilities.

(3) Remove stressors related to invasive plants, unmanaged livestock grazing, and small population size to *L. schaffneriana* ssp. *recurva* occurrences and their habitats.

(4) Develop a standardized monitoring technique based on existing protocols; monitor *L. schaffneriana* ssp. *recurva* occurrences, threats, and outcomes from management actions allowing for adaptive management.

(5) Encourage scientific study to improve our understanding of *L. schaffneriana* ssp. *recurva* geography, ecology, viability, genetics, propagation, restoration, and threats in the United States and Mexico.

(6) Develop public outreach, collaborative partnerships, agency management plans, and agreements with private land owners in the United States and Mexico that encourage *L. schaffneriana* ssp. *recurva* conservation.

The draft recovery plan focuses on conserving and enhancing habitat quality, protecting populations, managing threats, monitoring progress, and building partnerships to facilitate recovery. When the recovery of *L. schaffneriana* ssp. *recurva* approaches these criteria, we will review the species' status and consider downlisting, and, ultimately, removal from the list of federally threatened and endangered wildlife and plants.

Request for Public Comments

Section 4(f) of the Act requires us to provide public notice and an opportunity for public review and comment during recovery plan development. It is also our policy to request peer review of recovery plans (July 1, 1994; 59 FR 34270). In an appendix to the approved recovery plan, we will summarize and respond to the issues raised by the public and peer reviewers. Substantive comments may or may not result in changes to the recovery plan; comments regarding recovery plan implementation will be forwarded as appropriate to Federal or other entities so that they can be taken into account during the course of implementing recovery actions. Responses to individual commenters will not be provided, but we will provide a summary of how we addressed substantive comments in an appendix to the approved recovery plan.

We invite written comments on the draft recovery plan. In particular, we are interested in additional information regarding the current threats to the species and the costs associated with implementing the recommended recovery actions.

Before we approve our final recovery plan, we will consider all comments we receive by the date specified in **DATES** above. Methods of submitting comments are in the **ADDRESSES** section above.

Public Availability of Comments

Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Comments and materials we receive will be available, by appointment, for public inspection during normal business hours at our office (see **ADDRESSES**).

References Cited

A complete list of all references cited herein is available upon request from the Arizona Ecological Services Field Office (see **FOR FURTHER INFORMATION CONTACT** section).

Authority

We developed our draft recovery plan under the authority of section 4(f) of the Act, 16 U.S.C. 1533(f). We publish this notice under section 4(f) Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

Dated: March 1, 2016.

Joy E. Nicholopoulos.

Acting Regional Director, Southwest Region, U.S. Fish and Wildlife Service.

[FR Doc. 2016–05083 Filed 3–7–16; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[Docket No. FWS–HQ–IA–2016–0043; FXIA16710900000–156–FF09A30000]

Endangered Species; Receipt of Applications for Permit; Correction

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of receipt of applications for permit; correction.

SUMMARY: On February 25, 2016, we, the U.S. Fish and Wildlife Service, announced the receipt of applications for permits to conduct certain activities with endangered species. The notice contained the incorrect docket number for interested parties to use to submit comments. The correct docket number is FWS–HQ–IA–2016–0043. With this notice, we correct that error.

FOR FURTHER INFORMATION CONTACT: Brenda Tapia, (703) 358–2104 (telephone); (703) 358–2281 (fax); *DMAFR@fws.gov* (email).

SUPPLEMENTARY INFORMATION:

I. Public Comment Procedures

A. How Do I request copies of applications or comment on submitted applications?

Send your request for copies of applications or comments and materials concerning any of the applications to the contact listed under **ADDRESSES**. Please include the **Federal Register** notice publication date, the PRT-number, and the name of the applicant in your request or submission. We will not consider requests or comments sent to an email or address not listed under **ADDRESSES**. If you provide an email address in your request for copies of applications, we will attempt to respond to your request electronically.

Please make your requests or comments as specific as possible. Please confine your comments to issues for which we seek comments in this notice, and explain the basis for your comments. Include sufficient information with your comments to allow us to authenticate any scientific or commercial data you include.

The comments and recommendations that will be most useful and likely to influence agency decisions are: (1) Those supported by quantitative information or studies; and (2) Those that include citations to, and analyses of, the applicable laws and regulations. We will not consider or include in our administrative record comments we receive after the close of the comment period (see **DATES**) or comments delivered to an address other than those listed above (see **ADDRESSES**).

B. May I review comments submitted by others?

Comments, including names and street addresses of respondents, will be available for public review at the street address listed under **ADDRESSES**. The public may review documents and other information applicants have sent in support of the application unless our allowing viewing would violate the Privacy Act or Freedom of Information Act. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

II. Background

To help us carry out our conservation responsibilities for affected species, and in consideration of section 10(a)(1)(A) of the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*), along with Executive Order 13576, ''Delivering an Efficient, Effective, and Accountable Government,'' and the President's Memorandum for the Heads of Executive Departments and Agencies of January 21, 2009—Transparency and Open Government (74 FR 4685; January 26, 2009), which call on all Federal agencies to promote openness and transparency in Government by disclosing information to the public, we invite public comment on these permit applications before final action is taken.

III. Permit Applications

Endangered Species

Applicant: The Board of Trustees of the University of Illinois, Champaign, IL; PRT–84465A

The applicant requests an amendment to their permit to import samples from captive-born and wild hutia species (*Capromys species*), Cuban solenodon (*Solenodon cubanus*), Haitian/Hispaniolan solenodon (*Solenodon paradoxus*), Asian elephant (*Elephas maximus*), black rhinoceros (*Diceros bicornis*), Northern white rhinoceros (*Ceratotherium simum cottoni*), Javan rhinoceros (*Rhinoceros sondaicus*), Indian rhinoceros (*Rhinoceros unicornis*), Sumatran rhinoceros (*Dicerorhinus sumatrensis*), cheetah (Acinonyx jubatus), Pakistan sand cat (*Felis margarita scheffeli*), black-footed cat (*Felis nigripes*), Baird's tapir (*Tapirus bairdii*), lion (*Panthera leo leo*), and leopard (*panther pardus*) from multiple locations for the purpose of enhancement of the species through scientific research. This notification covers activities to be conducted by the applicant over a 5-year period.

Applicant: Wildlife Conservation Society, Bronx, NY; PRT–82159B

The applicant requests a permit to import two male captive-bred red-collared brown lemurs (*Eulemur collaris*) from Tierpark Berlin–Friedrichsfelde, Berlin, Germany, for the purpose of enhancement of the survival of the species through zoological display and captive propagation.

Applicant: Atlanta-Fulton County Zoo, dba Zoo Atlanta, Atlanta, GA; PRT–85599B

The applicant requests a permit to export two captive-bred female giant panda (*Ailuropoda melanoleuca*) to Chengdu Research Base of Giant Panda Breeding, Chengdu, China, for the purpose of enhancement of the survival of the species through conservation breeding.

Applicant: Steven Lambert, La Mesa CA; PRT–121977

The applicant requests an amendment to an existing captive-bred wildlife registration under 50 CFR 17.21(g) to add the following species to enhance species propagation or survival: Bolson tortoise (*Gopherus flavomarginatus*), aquatic box turtle (*Terrapene Coahuila*), yellow-spotted river turtle (*Podocnemis unifilis*), spotted pond turtle (*Geoclemys hamiltonii*), Grand Cayman blue iguana (*Cyclura lewisi*), and Cuban ground iguana (*Cyclura nubila nubila*). This notification covers activities to be conducted by the applicant over a 5-year period.

Applicant: U.S. Geological Survey, National Wildlife Health Center, Honolulu, HI; PRT–105568

The applicant requests a permit to import biological samples and carcasses from wild, captive-held, or captive born animals for the purpose of enhancement of the survival of the species and scientific research. This notification covers activities to be conducted by the applicant over a 5-year period.

Multiple Applicants

The following applicants each request a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus pygargus*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Carmelo Musacchia New York, NY; PRT–80906B

Applicant: Victor Sanchez, Humble, TX; PRT–84418B

Applicant: Thomas Salmon, Odessa, TX; PRT–86900B

Applicant: Danny Janecka, Waelder, TX; PRT–87863B

Dated: March 3, 2016.

Brenda Tapia,

Program Analyst/Data Administrator, Branch of Permits, Division of Management Authority.

[FR Doc. 2016–05140 Filed 3–7–16; 8:45 am]

BILLING CODE 4333–15–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLCA942000 L57000000.BX0000 15X L5017AR]

Filing of Plats of Survey: California

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The plats of survey of lands described below are scheduled to be officially filed in the Bureau of Land Management, California State Office, Sacramento, California.

DATES: April 7, 2016.

ADDRESSES: A copy of the plats may be obtained from the California State Office, Bureau of Land Management, 2800 Cottage Way, Sacramento, California 95825, upon required payment.

FOR FURTHER INFORMATION CONTACT: Chief, Branch of Geographic Services, Bureau of Land Management, California State Office, 2800 Cottage Way W–1623, Sacramento, California 95825, 1–916–978–4310. Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 to contact the above individual during normal business hours. The FIRS is available 24 hours a day, 7 days a week, to leave a message or question with the above individual. You will receive a reply during normal business hours.

SUPPLEMENTARY INFORMATION: A person or party who wishes to protest a survey must file a notice that they wish to protest with the Chief, Branch of Geographic Services. A statement of reasons for a protest may be filed with the notice of protest and must be filed with the Chief, Branch of Geographic Services within thirty days after the protest is filed. If a protest against the survey is received prior to the date of official filing, the filing will be stayed pending consideration of the protest. A plat will not be officially filed until the day after all protests have been dismissed or otherwise resolved. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Mount Diablo Meridian, California

T. 15 N., R. 12 W., supplemental plat, accepted January 11, 2016.
T. 6 S., R. 32 E., corrective dependent resurvey, dependent resurvey and subdivision of section 21, accepted February 5, 2016.
T. 2 N., R. 17 E., dependent resurvey and subdivision of sections, accepted February 11, 2016.
T. 23 N., R. 12 E., dependent resurvey and subdivision of section 3, accepted February 23, 2016.
T. 22 N., R. 12 E., dependent resurvey and subdivision of sections, accepted February 25, 2016.

San Bernardino Meridian, California

T. 8 S., R. 12 E., supplemental plat of section 2, accepted January 12, 2016.
T. 7 S., R. 13 E., supplemental plat of section 31, accepted January 12, 2016.
T. 8 S., R. 15 E., supplemental plat of section 3, accepted January 12, 2016.
T. 8 S., R. 15 E., supplemental plat of the NE 1/4 of section 11, accepted January 12, 2016.
T. 7 S., R. 14 E., supplemental plat of the NE 1/4 of the SE 1/4 of section 19, accepted January 13, 2016.
T. 8 S., R. 12 E., supplemental plat of the W 1/2 of section 5, accepted January 13, 2016.
T. 9 S., R. 13 E., supplemental plat of the NE 1/4 of section 26, accepted January 13, 2016.
T. 10 S., R. 14 E., supplemental plat of a portion of the NE 1/4 of section 8, accepted January 13, 2016.
T. 8 S., R. 16 E., supplemental plat of the NE 1/4 of section 16, accepted January 27, 2016.
T. 8 S., R. 16 E., supplemental plat of the NE 1/4 of section 36, accepted January 27, 2016.
T. 10 S., R. 14 E., supplemental plat of section 5, accepted January 27, 2016.
T. 10 S., R. 15 E., supplemental plat of the SW 1/4 of section 33, accepted January 27, 2016.
T. 8 S., R. 12 E., supplemental plat of section 27, accepted January 27, 2016.
T. 8 S., R. 12 E., supplemental plat of the NW 1/4 of the NW 1/4 of section 26, accepted January 28, 2016.
T. 10 S., R. 15 E., supplemental plat of section 29, accepted January 28, 2016.
T. 9 S., R. 17 E., supplemental plat of sections 26 through 36, accepted February 2, 2016.
T. 10 S., R. 19 E., supplemental plat of sections 31 and 32, accepted February 2, 2016.
T. 4 S., R. 4 W., supplemental plat of section 32, accepted February 9, 2016.
T. 8 S., R. 12 E., supplemental plat of section 36, accepted February 12, 2016.
T. 8 S., R. 12 E., supplemental plat of the NE 1/4 of section 7, accepted February 12, 2016.
T. 8 S., R. 13 E., supplemental plat of the SW 1/4 of section 31, accepted February 12, 2016.
T. 9 S., R. 13 E., supplemental plat of section 7, accepted February 12, 2016.
T. 9 S., R. 13 E., supplemental plat of section 22, accepted February 12, 2016.
T. 9 S., R. 13 E., supplemental plat of the NE 1/4 of section 21, accepted February 12, 2016.
T. 2 N., R. 5 W., dependent resurvey and subdivision of sections, accepted February 23, 2016.

Authority: 43 U.S.C., Chapter 3.

Dated: February 26, 2016.

Jon L. Kehler,

(Acting) Chief Cadastral Surveyor, California.

[FR Doc. 2016–05087 Filed 3–7–16; 8:45 am]

BILLING CODE 4310–40–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–20249; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: University of Denver Museum of Anthropology, Denver, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The University of Denver Museum of Anthropology has completed an inventory of human remains and associated funerary objects,

in consultation with the appropriate Indian tribes or Native Hawaiian organizations, and has determined that there is no cultural affiliation between the human remains and associated funerary objects and any present-day Indian tribes or Native Hawaiian organizations. Representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to the University of Denver Museum of Anthropology. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the Indian tribes or Native Hawaiian organizations stated in this notice may proceed.

DATES: Representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to the University of Denver Museum of Anthropology at the address in this notice by April 7, 2016.

ADDRESSES: Anne Amati, University of Denver Museum of Anthropology, 2000 E Asbury Avenue, Denver, CO 80208, telephone (303) 871–2687, email *anne.amati@du.edu*.

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control of the University of Denver Museum of Anthropology, Denver, CO. The human remains and associated funerary objects were removed from unknown locations.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains was made by the University of Denver Museum of Anthropology professional staff in consultation with representatives of the Arapaho Tribe of the Wind River Reservation, Wyoming; Cheyenne and Arapaho Tribes, Oklahoma (previously listed as the Cheyenne-Arapaho Tribes of Oklahoma); Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Comanche Nation, Oklahoma; Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota; Hopi Tribe of Arizona; Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana; Ohkay Owingeh, New Mexico (previously listed as the Pueblo of San Juan); Pueblo of Acoma, New Mexico; Pueblo of Cochiti, New Mexico; Pueblo of Isleta, New Mexico; Pueblo of Jemez, New Mexico; Pueblo of San Felipe, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Santa Clara, New Mexico; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; The Osage Nation (previously listed as the Osage Tribe); Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota; Ute Indian Tribe of the Uintah & Ouray Reservation, Utah; Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah; Wichita and Affiliated Tribes (Wichita, Keechi, Waco & Tawakonie), Oklahoma; Ysleta del Sur Pueblo (previously listed as the Ysleta Del Sur Pueblo of Texas); and Zuni Tribe of the Zuni Reservation, New Mexico.

The following tribes were also invited to participate but were not involved in consultations: Apache Tribe of Oklahoma; Crow Tribe of Montana; Fort Sill Apache Tribe of Oklahoma; Jicarilla Apache Nation, New Mexico; Kewa Pueblo, New Mexico (previously listed as the Pueblo of Santo Domingo); Kiowa Indian Tribe of Oklahoma; Mescalero Apache Tribe of the Mescalero Reservation, New Mexico; Navajo Nation, Arizona, New Mexico & Utah; Oglala Sioux Tribe (previously listed as the Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota); Paiute Indian Tribe of Utah (Cedar Band of Paiutes, Kanosh Band of Paiutes, Koosharem Band of Paiutes, Indian Peaks Band of Paiutes, and Shivwits Band of Paiutes) (previously listed as Paiute Indian Tribe of Utah (Cedar City Band of Paiutes, Kanosh Band of Paiutes, Koosharem Band of Paiutes, Indian Peaks Band of Paiutes, and Shivwits Band of Paiutes)); Pawnee Nation of Oklahoma; Pueblo of Laguna, New Mexico; Pueblo of Nambe, New Mexico; Pueblo of Picuris, New Mexico; Pueblo of Pojoaque, New Mexico; Pueblo of San Ildefonso, New Mexico; Pueblo of Sandia, New Mexico; Pueblo of Taos, New Mexico; Pueblo of Tesuque, New Mexico; Pueblo of Zia, New Mexico; Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota; San Juan Southern Paiute Tribe of Arizona; Shoshone Tribe of the Wind River Reservation, Wyoming; Shoshone-Bannock Tribes of the Fort Hall Reservation; and Standing Rock Sioux Tribe of North & South Dakota.

Hereafter, all tribes listed in this section are referred to as ''The Consulted and Notified Tribes.''

History and Description of the Remains

At an unknown date, human remains representing, at minimum, 66 individuals (DU #s 6003, 6007, 6008, 6012, 6013, 6016–6053, 6057, 6075, 6135, 6165–6172, 6182, 6199, and 6401–6430) were removed from multiple unknown locations. The human remains came into the possession of the University of Denver Museum of Anthropology at an unknown date and were entered into museum collection records in 1987 or 1988. In 1988, all human and animal bones and casts in the possession of the Museum of Anthropology were moved from the Mary Reed Building to the Science Hall on the University of Denver campus. Museum staff believes these human remains were in the possession of the University of Denver Museum of Anthropology prior to the 1988 move and were catalogued as part of that move. No known individuals were identified. The four associated funerary objects (associated with DU #6199) are four animal teeth.

At an unknown date, human remains representing, at minimum, six individuals (DU #s 6061, 6068–6070, and 6181) were removed from multiple unknown locations. The human remains came into the possession of the University of Denver Museum of Anthropology between the 1930s and 1950s and were entered into museum collection records in 1987 or 1988. During NAGPRA Inventory research, previous museum staff linked these individuals to Dr. E.B. Renaud, who was at DU from the 1930s to the 1950s. No known individuals were identified. No associated funerary objects are present.

At an unknown date, human remains representing, at minimum, 17 individuals (6601–6617) were removed from multiple unknown locations. The human remains were acquired by the University of Denver Department of Anthropology in 1982 from the Colorado Women's College. The human remains were acquired as teaching aids and used in Dr. Jonathan Haas's ''dig'' lab. The lab recreated an archeology site in the Science Hall basement and ran between 1983 and 1985. No known individuals were identified. No associated funerary objects are present.

At an unknown date, human remains representing, at minimum, five

individuals (DU #s 1995.1.5, 1995.1.9, 1995.1.10, 1995.1.12, 1995.1.14) were removed from multiple unknown locations. The human remains were part of the collection of Theodore Sowers. Mr. Sowers, a student of Dr. E.B. Renaud, graduated from the University of Denver with a BA in Anthropology in 1938. Following his death, Mr. Sowers' daughters, Katy Sickles and Jenny Bauer, inherited the collection. They donated the entire collection (over 3,000 catalog records) to the University of Denver Museum of Anthropology in 1995 to facilitate repatriation. No known individuals were identified. The eight associated funerary objects (associated with 1995.1.5) are five worked non-human bones, one worked horn, one animal tooth, and one black stone pipe.

At an unknown date, human remains representing, at minimum, two individuals (DU #s No number-Individual 1 and 2) were removed from multiple unknown locations. Previous museum staff first documented these human remains during the NAGPRA Inventory in 1995. There is no additional information associated with these individuals. No known individuals were identified. No associated funerary objects are present.

The University of Denver Museum of Anthropology is a research museum with archeological collections focused in the southwestern United States. The 96 individuals described above have little to no documentation associated with them and no provenience information. Colorado has been their home for between 19 and 70 years.

Pursuant to 43 CFR 10.16, the Secretary of the Interior may make a recommendation for a transfer of control of culturally unidentifiable human remains and associated funerary objects. In September 2015, the University of Denver Museum of Anthropology requested that the Secretary, through the Native American Graves Protection and Repatriation Review Committee, recommend the proposed transfer of control of the culturally unidentifiable Native American human remains and associated funerary objects in this notice to Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah. The Review Committee, acting pursuant to its responsibility under 25 U.S.C. 3006(c)(5), considered the request at its November 2015 meeting and recommended to the Secretary that the proposed transfer of control proceed. A January 2016 letter on behalf of the Secretary of Interior from the Associate Director, Cultural Resources, Partnerships, and Science, transmitted the Secretary's independent review and concurrence with the Review Committee that:

- The University of Denver Museum of Anthropology consulted with every appropriate Indian tribe or Native Hawaiian organization, and
- the University of Denver Museum of Anthropology may proceed with the agreed upon transfer of control of the culturally unidentifiable human remains and associated funerary objects to the Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah.

Transfer of control is contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement.

Determinations Made by the University of Denver Museum of Anthropology

Officials of the University of Denver Museum of Anthropology have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice are Native American based on the broader collecting practices of the University of Denver Museum of Anthropology and the findings of a physical anthropologist employed by the University of Denver prior to November 1995.
- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of 96 individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the 12 objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- Pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and associated funerary objects and any present-day Indian tribe.
- Pursuant to 43 CFR 10.16, the disposition of the human remains and associated funerary objects will be to Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah.

Additional Requestors and Disposition

Representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Anne Amati, University of Denver Museum of Anthropology, 2000 E. Asbury Avenue, Denver, CO 80208, telephone (303) 871–2687, email *anne.amati@du.edu,* by April 7, 2016. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects to the Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah may proceed.

The University of Denver Museum of Anthropology is responsible for notifying The Consulted and Notified Tribes that this notice has been published.

Dated: February 3, 2016.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2016–05064 Filed 3–7–16; 8:45 am]

BILLING CODE 4312–50–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–20250; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion for Native American Human Remains and Associated Funerary Objects in the Possession of the University of Denver Department of Anthropology and Museum of Anthropology, Denver, CO; Correction

AGENCY: National Park Service, Interior.

ACTION: Notice; correction.

SUMMARY: The University of Denver Museum of Anthropology has corrected an inventory of human remains and associated funerary objects, published in a Notice of Inventory Completion in the **Federal Register** on November 13, 2000. This notice corrects the number of associated funerary objects. Lineal descendants or representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these associated funerary objects should submit a written request to the University of Denver Museum of Anthropology. If no additional requestors come forward, transfer of control of the associated funerary objects to the lineal descendants, Indian tribes, or Native Hawaiian organizations stated in this notice may proceed.

DATES: Lineal descendants or representatives of any Indian tribe or Native Hawaiian organization not

identified in this notice that wish to request transfer of control of these associated funerary objects should submit a written request with information in support of the request to the University of Denver Museum of Anthropology at the address in this notice by April 7, 2016.

ADDRESSES: Anne Amati, University of Denver Museum of Anthropology, 2000 East Asbury Avenue, Denver, CO 80208, telephone (303) 871–2687, email *anne.amati@du.edu.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the correction of an inventory of human remains and associated funerary objects under the control of the University of Denver Museum of Anthropology, Denver, CO. The human remains and associated funerary objects were removed from Pueblo Blanco, Santa Fe County, NM.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

This notice corrects the number of associated funerary objects published in a Notice of Inventory Completion in the **Federal Register** (65 FR 67757–67758, November 13, 2000). Re-inventory discovered more associated funerary objects. Transfer of control of the items in this correction notice has not occurred.

Correction

In the **Federal Register** (65 FR 67757–67758, November 13, 2000), paragraph 4, sentence 4 is corrected by substituting the following sentence:

The 21 associated funerary objects are 1 non-human bone, 15 ceramic sherds (black and red on white), 4 chipped stone tools, and 1 projectile point fragment.

In the **Federal Register** (65 FR 67757–67758, November 13, 2000), paragraph 6, sentence 2 is corrected by substituting the following sentence:

Officials of the University of Denver Department of Anthropology and Museum of Anthropology also have determined that, pursuant to 43 CFR 10.2 (d)(2), the 21 objects listed above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.

Additional Requestors and Disposition

Lineal descendants or representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Anne Amati, University of Denver Museum of Anthropology, 2000 E. Asbury Avenue, Denver, CO 80208, telephone (303) 871–2687, email *anne.amati@du.edu,* by April 7, 2016. After that date, if no additional requestors have come forward, transfer of control of the and associated funerary objects to the Hopi Tribe of Arizona may proceed.

The University of Denver Museum of Anthropology is responsible for notifying the Hopi Tribe of Arizona and the Colorado River Indian Tribes of the Colorado River Indian Reservation, Arizona and California, that this notice has been published.

Dated: February 3, 2016.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2016–05061 Filed 3–7–16; 8:45 am]

BILLING CODE 4312–50–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–20267; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: Tennessee Valley Authority, Knoxville, TN

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The Tennessee Valley Authority (TVA) has completed an inventory of human remains and associated funerary objects in consultation with the appropriate Federally recognized Indian tribes and has determined that there is no cultural affiliation between the human remains and associated funerary objects and any present-day federally recognized Indian tribes. Representatives of any federally recognized Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to Tennessee Valley Authority. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the federally recognized Indian tribes stated in this notice may proceed.

DATES: Representatives of any federally recognized Indian tribe not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to TVA at the address in this notice by April 7, 2016.

ADDRESSES: Dr. Thomas O. Maher, Tennessee Valley Authority, 400 West Summit Hill Drive, WT11D, Knoxville, TN 37902–1401, telephone (865) 632–7458, email *tomaher@tva.gov.*

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control and possession of TVA. The human remains and associated funerary objects were removed from site 40SM113, in Smith County, TN, in 1976.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3) and 43 CFR 10.11(d). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

Consultation

A detailed assessment of the human remains and associated funerary objects was made by TVA's professional staff. Representatives of the following tribes were notified on January 29, 2015: Absentee-Shawnee Tribe of Indians of Oklahoma; Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Alabama-Quassarte Tribal Town; Cherokee Nation; Coushatta Tribe of Louisiana; Eastern Band of Cherokee Indians; Eastern Shawnee Tribe of Oklahoma; Kialegee Tribal Town; Shawnee Tribe; The Chickasaw Nation; The Muscogee (Creek) Nation; Thlopthlocco Tribal Town; and the United Keetoowah Band of Cherokee Indians in Oklahoma. A telephone conference to consult on this repatriation took place on April 24, 2015, with tribal representatives of the Eastern Band of Cherokee Indians, The Muscogee (Creek) Nation, and the United Keetoowah Band of Cherokee Indians in Oklahoma. The inability to determine whether aboriginal lands were implicated in this NAGPRA disposition led to further consultation with the tribes on June 15, 2015.

As a result of this further consultation, TVA received requests for joint transfer of control of the human remains and associated funerary objects from the Cherokee Nation, the Eastern Band of Cherokee Indians, the Eastern Shawnee Tribe of Oklahoma, The Muscogee (Creek) Nation, the Thlopthlocco Tribal Town, the Shawnee Tribe, and the United Keetoowah Band of Cherokee Indians in Oklahoma. No objections to this joint transfer of control were received from the Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas), the Alabama-Quassarte Tribal Town, the Chickasaw Nation, and the Coushatta Tribe of Louisiana.

History and Description of the Remains

In April 1976, human remains representing, at minimum, one individual were removed from the Dixon Creek site, 40SM113. The Dixon Creek site, 40SM113, was first recorded in 1972 as SI–1 (Surface Indication 1) by Major McCollough of the University of Tennessee (McCollough 1972). Under contract with TVA, Steven Fox completed additional survey work between 1974 and 1976. In April 1976, four test units were excavated. Test Unit 4 uncovered the only human remains and associated funerary objects found at this site. A single adult male Native American was interred in a semi-flexed position within a 5×4 foot burial pit. No known individuals were identified. The two associated funerary objects are two shell-tempered ceramic vessels.

The vessels found with the human remains appear to place the burial in the Middle Cumberland Mississippian period, A.D. 1050–1450. The lack of any detailed information on these human remains and funerary objects leads TVA to designate them as culturally unidentifiable.

Site 40SM113 is in Smith County, TN, north of the Cumberland River. The site is outside the boundary of any areas recognized in a final judgment of the Indian Claims Commission or the United States Court of Claims. Although there are no treaties between the United States Government and a Native American tribe for this area, there was a treaty negotiated before the creation of the U.S.A. Richard Henderson, representing the Transylvania Company, met with the Cherokee to negotiate the purchase of land including Smith County, TN, for the creation of a 14th colony on March 14, 1775. The Treaty of Sycamore Shoals was not acknowledged by the United States Government or the governments of the states of Virginia and North Carolina. An unratified treaty cannot be used to identify aboriginal lands (75 FR 49, March 15, 2010).

Pursuant to 43 CFR 10.16, the Secretary of the Interior may make a recommendation for a transfer of control of culturally unidentifiable human remains and associated funerary objects. Tennessee Valley Authority requested that the Secretary, through the Native American Graves Protection and Repatriation Review Committee, recommend the proposed transfer of control of the culturally unidentifiable human remains and associated funerary objects in this notice to the Cherokee Nation, the Eastern Band of Cherokee Indians, the Eastern Shawnee Tribe of Oklahoma, The Muscogee (Creek) Nation, the Thlopthlocco Tribal Town, the Shawnee Tribe, and the United Keetoowah Band of Cherokee Indians in Oklahoma. No objections to this joint transfer of control were received from the Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas), the Alabama-Quassarte Tribal Town, the Chickasaw Nation, and the Coushatta Tribe of Louisiana.

Determinations Made By the Tennessee Valley Authority

Officials of TVA have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains and associated funerary objects described in this notice are Native American based on their presence in prehistoric archeological contexts.
- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of one individual of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the two objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony.
- Pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and any present-day Indian tribe.
- Pursuant to 43 CFR 10.11, the ''tribal land'' or the ''aboriginal land'' provenience of the human remains cannot be determined.
- Pursuant to 43 CFR 10.16, the disposition of the human remains and associated funerary objects will be to the Cherokee Nation, the Eastern Band of Cherokee Indians, the Eastern Shawnee Tribe of Oklahoma, The Muscogee (Creek) Nation, the Shawnee Tribe, the Thlopthlocco Tribal Town, and the United Keetoowah Band of Cherokee Indians in Oklahoma for a joint disposition of the human remains and associated funerary objects to these federally recognized tribes.

Additional Requestors and Disposition

Representatives of any federally recognized Indian tribe not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Dr. Thomas O. Maher, Tennessee Valley Authority, 400 West Summit Hill Drive, WT11D, Knoxville, TN 37902–1401, telephone (865) 632–7458, email *tomaher@tva.gov,* by April 7, 2016. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects to the Cherokee Nation, the Eastern Band of Cherokee Indians, the Eastern Shawnee Tribe of Oklahoma, the Shawnee Tribe, The Muscogee (Creek) Nation, the Thlopthlocco Tribal Town, and the United Keetoowah Band of Cherokee Indians in Oklahoma may proceed.

TVA is responsible for notifying the Absentee-Shawnee Tribe of Indians of Oklahoma; Alabama-Coushatta Tribe of Texas (previously listed as the Alabama-Coushatta Tribes of Texas); Alabama-Quassarte Tribal Town; Coushatta Tribe of Louisiana; Cherokee Nation; Eastern Band of Cherokee Indians; Eastern Shawnee Tribe of Oklahoma; Kialegee Tribal Town; Shawnee Tribe; The Chickasaw Nation; The Muscogee (Creek) Nation; Thlopthlocco Tribal Town; and the United Keetoowah Band of Cherokee Indians in Oklahoma that this notice has been published.

Dated: February 4, 2016.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2016–05063 Filed 3–7–16; 8:45 am]

BILLING CODE 4312–50–P

DEPARTMENT OF THE INTERIOR

National Park Service

[NPS–WASO–NAGPRA–20265; PPWOCRADN0–PCU00RP14.R50000]

Notice of Inventory Completion: U.S. Department of the Interior, National Park Service, Chaco Culture National Historical Park, Nageezi, NM

AGENCY: National Park Service, Interior.

ACTION: Notice.

SUMMARY: The U.S. Department of the Interior, National Park Service, Chaco Culture National Historical Park has completed an inventory of human

remains and associated funerary objects, in consultation with the appropriate Indian tribes or Native Hawaiian organizations, and has determined that there is no cultural affiliation between the human remains and associated funerary objects and any present-day Indian tribes or Native Hawaiian organizations. Representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request to Chaco Culture National Historical Park. If no additional requestors come forward, transfer of control of the human remains and associated funerary objects to the Indian tribes or Native Hawaiian organizations stated in this notice may proceed.

DATES: Representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Chaco Culture National Historical Park at the address in this notice by April 7, 2016.

ADDRESSES: Lawrence Turk, Superintendent, Chaco Culture National Historical Park, P.O. Box 220, Nageezi, NM 87307, telephone (505) 786–7014, email *larry_turk@nps.gov*.

SUPPLEMENTARY INFORMATION: Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects under the control of the U.S. Department of the Interior, National Park Service, Chaco Culture National Historical Park, Nageezi, NM. The human remains and associated funerary objects were removed from unknown locations within a 100 mile radius of Shiprock, NM.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the Superintendent, Chaco Culture National Historical Park.

Consultation

A detailed assessment of the human remains was made by Chaco Culture National Historical Park professional staff in consultation with representatives of the Hopi Tribe of Arizona; Jicarilla Apache Nation, New Mexico; Mescalero Apache Tribe of the Mescalero Reservation, New Mexico; Navajo Nation, Arizona, New Mexico & Utah; Ohkay Owingeh, New Mexico (previously listed as the Pueblo of San Juan); Pueblo of Acoma, New Mexico; Pueblo of Isleta, New Mexico; Pueblo of Jemez, New Mexico; Pueblo of Laguna, New Mexico; Pueblo of Nambe, New Mexico; Pueblo of Pojoaque, New Mexico; Pueblo of San Felipe, New Mexico; Pueblo of San Ildefonso, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Santa Clara, New Mexico; Pueblo of Tesuque, New Mexico; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; and Zuni Tribe of the Zuni Reservation, New Mexico (hereafter referred to as ''The Consulted Tribes'').

The following tribes were contacted but did not participate in the face-to-face consultation meetings: Arapaho Tribe of the Wind River Reservation, Wyoming; Cheyenne and Arapaho Tribes, Oklahoma (previously listed as the Cheyenne-Arapaho Tribes of Oklahoma); Kewa Pueblo, New Mexico (previously listed as the Pueblo of Santo Domingo); Pueblo of Cochiti, New Mexico; Pueblo of Picuris, New Mexico; Pueblo of Sandia, New Mexico; Pueblo of Taos, New Mexico; Pueblo of Zia, New Mexico; San Carlos Apache Tribe of the San Carlos Reservation, Arizona; Tonto Apache Tribe of Arizona; Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah; White Mountain Apache Tribe of the Fort Apache Reservation, Arizona; and Ysleta Del Sur Pueblo (previously listed as the Ysleta Del Sur Pueblo of Texas), (hereafter referred to as ''The Invited Tribes'').

History and Description of the Remains

Between 1928 and 1938, human remains representing, at minimum, two individuals were removed from unknown locations within a radius of one hundred miles of Shiprock, NM, by Harold H. Harkness, of Escondido, CA. The human remains were taken into the custody of Chaco Canyon National Monument in 1938. No known individuals were identified. The eight associated funerary objects are one textile, two wooden combs, one wooden duck effigy, one horn artifact, one worked shell artifact, one bone artifact, and one leather artifact.

Pursuant to 43 CFR 10.16, the Secretary of the Interior may make a recommendation for a transfer of control of culturally unidentifiable human remains and associated funerary objects. In September 2015, Chaco Culture National Historical Park requested that the Secretary, through the Native American Graves Protection and Repatriation Review Committee, recommend the proposed transfer of control of the culturally unidentifiable Native American human remains and associated funerary objects in this notice to the Hopi Tribe of Arizona and the Navajo Nation, Arizona, New Mexico & Utah. The Review Committee, acting pursuant to its responsibility under 25 U.S.C. 3006(c)(5), considered the request at its November 2015 meeting and recommended to the Secretary that the proposed transfer of control proceed. A January 2016 letter on behalf of the Secretary of the Interior from the Associate Director, Cultural Resources, Partnerships, and Science transmitted the Secretary's independent review and concurrence with the Review Committee that:

- None of The Consulted Tribes objected to the proposed transfer of control and
- Chaco Culture National Historical Park may proceed with the agreed upon transfer of control of the culturally unidentifiable human remains and associated funerary objects to the Hopi Tribe of Arizona and the Navajo Nation, Arizona, New Mexico & Utah.

Transfer of control is contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement.

Determinations Made by Chaco Culture National Historical Park

Officials of Chaco Culture National Historical Park have determined that:

- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice are Native American based on osteological analysis.
- Pursuant to 25 U.S.C. 3001(9), the human remains described in this notice represent the physical remains of two individuals of Native American ancestry.
- Pursuant to 25 U.S.C. 3001(3)(A), the eight objects described in this notice are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony. The National Park Service intends to convey the associated funerary objects to the tribes pursuant to 54 U.S.C. 102503(g) through (i) and 54 U.S.C 102504.
- Pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and associated funerary objects and any present-day Indian tribe.
- Pursuant to 43 CFR 10.16, the disposition of the human remains and associated funerary objects will be to the Hopi Tribe of Arizona and the Navajo Nation, Arizona, New Mexico & Utah.

Additional Requestors and Disposition

Representatives of any Indian tribe or Native Hawaiian organization not identified in this notice that wish to request transfer of control of these human remains and associated funerary objects should submit a written request with information in support of the request to Lawrence Turk, Superintendent, Chaco Culture National Historical Park, P.O. Box 220, Nageezi, NM 87307, telephone (505) 786–7014, email *larry_turk@nps.gov,* by April 7, 2016. After that date, if no additional requestors have come forward, transfer of control of the human remains and associated funerary objects to the Hopi Tribe of Arizona and the Navajo Nation, Arizona, New Mexico & Utah may proceed.

Chaco Culture National Historical Park is responsible for notifying The Consulted Tribes and The Invited Tribes that this notice has been published.

Dated: February 4, 2016.

Melanie O'Brien,

Manager, National NAGPRA Program.

[FR Doc. 2016–05062 Filed 3–7–16; 8:45 am]

BILLING CODE 4312–50–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

[S1D1S SS08011000 SX064A000 167S180110; S2D2S SS08011000 SX064A000 16XS501520]

Notice of Proposed Information Collection; Request for Comments for 1029–0051

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Office of Surface Mining Reclamation and Enforcement (OSMRE) is announcing that the information collection request for the State Regulatory Authority: Inspection and Enforcement, has been forwarded to the Office of Management and Budget (OMB) for review and approval. This information collection request describes the nature of the information collection and its expected burden and cost.

DATES: OMB has up to 60 days to approve or disapprove the information collection requests but may respond after 30 days. Therefore, public comments should be submitted to OMB by April 7, 2016, in order to be assured of consideration.

ADDRESSES: Submit comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Department of the Interior Desk Officer, via email at *OIRA_submission@omb.eop.gov,* or by facsimile to (202) 395–5806. Also, please send a copy of your comments to John Trelease, Office of Surface Mining Reclamation and Enforcement, 1951 Constitution Ave NW., Room 203—SIB, Washington, DC 20240, or electronically to *jtrelease@osmre.gov.* Please reference 1029–0051 in your correspondence.

FOR FURTHER INFORMATION CONTACT: To receive a copy of the information collection request, contact John Trelease at (202) 208–2783. You may also contact Mr. Trelease at *jtrelease@osmre.gov.*

SUPPLEMENTARY INFORMATION: OMB regulations at 5 CFR part 1320, which implement provisions of the Paperwork Reduction Act of 1995 (Pub. L. 104–13), require that interested members of the public and affected agencies have an opportunity to comment on information collection and recordkeeping activities [see 5 CFR 1320.8(d)]. OSMRE has submitted the request to OMB to renew its approval for the collection of information found at 30 CFR part 840. OSMRE is requesting a 3-year term of approval for this information collection activity.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection of information is 1029–0051, and may be found in OSMRE's regulations at 30 CFR 840.10. State agencies are required to respond to obtain a benefit.

As required under 5 CFR 1320.8(d), a **Federal Register** notice soliciting comments on this collection was published on December 9, 2015 (80 FR 76572). No comments were received. This notice provides the public with an additional 30 days in which to comment on the following information collection activity:

Title: 30 CFR part 840—State Regulatory Authority: Inspection and Enforcement.

OMB Control Number: 1029–0051.

Abstract: This provision requires the regulatory authority to conduct periodic inspections of coal mining activities, and prepare and maintain inspection reports for public review. This information is necessary to meet the requirements of the Surface Mining Control and Reclamation Act of 1977 and its public participation provisions. Public review assures that the State is meeting the requirements for the Act and approved State regulatory program.

Bureau Form Number: None.

Frequency of Collection: Once, monthly, quarterly and annually.

Description of Respondents: State Regulatory Authorities.

Total Annual Responses: 52,121.

Total Annual Burden Hours: 296,938.

Total Non-wage Costs: $2,300.

Obligation to Respond: Required in order to obtain or retain benefits.

Send comments on the need for the collection of information for the performance of the functions of the agency; the accuracy of the agency's burden estimates; ways to enhance the quality, utility and clarity of the information collection; and ways to minimize the information collection burden on respondents, such as use of automated means of collection of the information, to the places listed in **ADDRESSES**. Please refer to control number 1029–0051 in all correspondence.

Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Dated: *March 2, 2016.*

John A. Trelease,

Acting Chief, Division of Regulatory Support.

[FR Doc. 2016–05144 Filed 3–7–16; 8:45 am]

BILLING CODE 4310–05–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

[S1D1S SS08011000 SX064A000 167S180110; S2D2S SS08011000 SX064A000 16XS501520]

Notice of Proposed Information Collection; Request for Comments for 1029–0057

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Office of Surface Mining Reclamation and Enforcement (OSMRE) is announcing that the information collection request for Reclamation on Private Land, has been forwarded to the

Office of Management and Budget (OMB) for review and approval. This information collection activity was previously approved by OMB and assigned control number 1029–0057. This information collection request describes the nature of the information collection and its expected burden and cost.

DATES: OMB has up to 60 days to approve or disapprove the information collection requests but may respond after 30 days. Therefore, public comments should be submitted to OMB by April 7, 2016, in order to be assured of consideration.

ADDRESSES: Submit comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Department of the Interior Desk Officer, via email at *OIRA_submission@omb.eop.gov,* or by facsimile to (202) 395–5806. Also, please send a copy of your comments to John Trelease, Office of Surface Mining Reclamation and Enforcement, 1951 Constitution Ave. NW., Room 203—SIB, Washington, DC 20240, or electronically to *jtrelease@osmre.gov.* Please reference 1029–0057 in your correspondence.

FOR FURTHER INFORMATION CONTACT: To receive a copy of the information collection request contact John Trelease at (202) 208–2783, or electronically at *jtrelease@osmre.gov.* You may also review the information collection request online at *http://www.reginfo.gov.* Follow the instructions to review Department of the Interior collections under review by OMB.

SUPPLEMENTARY INFORMATION: OMB regulations at 5 CFR 1320, which implement provisions of the Paperwork Reduction Act of 1995 (Pub. L. 104–13), require that interested members of the public and affected agencies have an opportunity to comment on information collection and recordkeeping activities [see 5 CFR 1320.8(d)]. OSMRE has submitted the request to OMB to renew its approval for the collection of information found at 30 CFR part 882. OSMRE is requesting a 3-year term of approval for this information collection activity.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection of information is 1029–0057, and may be found in OSMRE's regulations at 30 CFR 882.10.

As required under 5 CFR 1320.8(d), a **Federal Register** notice soliciting comments on this collection was published on December 22, 2015 (80 FR 79611). No comments were received. This notice provides the public with an additional 30 days in which to comment on the following information collection activity:

Title: 30 CFR part 882—Reclamation on Private Land.

OMB Control Number: 1029–0057.

Summary: Public Law 95–87 authorizes Federal, State, and Tribal governments to reclaim private lands and allows for the establishment of procedures for the recovery of the cost of reclamation activities on privately owned lands. These procedures are intended to ensure that governments have sufficient capability to file liens so that certain landowners will not receive a windfall from reclamation.

Bureau Form Number: None.

Frequency of Collection: Once.

Description of Respondents: State governments and Indian tribes.

Total Annual Responses: 1.

Total Annual Burden Hours: 120.

Obligation to Respond: Required in order to obtain or retain benefits.

Send comments on the need for the collection of information for the performance of the functions of the agency; the accuracy of the agency's burden estimates; ways to enhance the quality, utility and clarity of the information collection; and ways to minimize the information collection burden on respondents, such as use of automated means of collection of the information, to the places listed in **ADDRESSES**. Please refer to control number 1029–0057 in all correspondence.

Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Dated: March 3, 2016.

John A. Trelease,

Acting Chief, Division of Regulatory Support.

[FR Doc. 2016–05148 Filed 3–7–16; 8:45 am]

BILLING CODE 4310–05–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

[S1D1S SS08011000 SX064A000 167S180110; S2D2S SS08011000 SX064A000 16XS501520]

Notice of Proposed Information Collection; Request for Comments for 1029–0115

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Office of Surface Mining Reclamation and Enforcement (OSMRE) is announcing that the information collection request for the requirements for permits and permit processing has been submitted to the Office of Management and Budget (OMB) for review and approval. The information collection package was previously approved and assigned control number 1029–0115. This information collection will also seek approval to collect permit processing fees approved under OSM regulations. This notice describes the nature of the information collection activity and the expected burdens.

DATES: OMB has up to 60 days to approve or disapprove the information collection but may respond after 30 days. Therefore, public comments should be submitted to OMB by April 7, 2016, in order to be assured of consideration.

ADDRESSES: Submit comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Department of the Interior Desk Officer, by telefax at (202) 395–5806 or via email to *OIRA_Submission@omb.eop.gov.* Also, please send a copy of your comments to John Trelease, Office of Surface Mining Reclamation and Enforcement, 1951 Constitution Ave. NW., Room 203—SIB, Washington, DC 20240, or electronically to *jtrelease@osmre.gov.* Please reference 1029–0115 in your correspondence.

FOR FURTHER INFORMATION CONTACT: To receive a copy of the information collection request contact John Trelease at (202) 208–2783, or electronically at *jtrelease@osmre.gov.* You may also review this information collection request on the Internet by going to *http://www.reginfo.gov* (Information Collection Review, Currently Under Review, Agency is Department of the Interior, DOI–OSMRE).

SUPPLEMENTARY INFORMATION: OMB regulations at 5 CFR part 1320, which implement provisions of the Paperwork Reduction Act of 1995 (Pub. L. 104–13), require that interested members of the public and affected agencies have an opportunity to comment on information collection and recordkeeping activities [see 5 CFR 1320.8(d)]. OSM has submitted a request to OMB to renew its approval for the collection of information for 30 CFR part 773—Requirements for Permits and Permit Processing. OSM is requesting a 3-year term of approval for this information collection activity.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection, 1029–0115, is listed in 30 CFR 773.3.

As required under 5 CFR 1320.8(d), a **Federal Register** notice soliciting comments on these collections of information was published on December 9, 2015 (80 FR 76571). No comments were received. This notice provides the public with an additional 30 days in which to comment on the following collection activity:

Title: 30 CFR part 773—Requirements for Permits and Permit Processing.

OMB Control Number: 1029–0115.

Summary: The collection activities for this Part ensure that the public has the opportunity to review permit applications prior to their approval, and that applicants for permanent program permits or their associates who are in violation of the Surface Mining Control and Reclamation Act do not receive surface coal mining permits pending resolution of their violations. This collection request includes the submission of processing fees authorized by 30 CFR 736.25 and 750.25 in Federal program states and on Indian lands, respectively.

Bureau Form Number: None.

Frequency of Collection: Once.

Description of Respondents: Applicants for surface coal mining and reclamation permits and State governments and Indian Tribes.

Total Annual Respondents: 942 coal mining applicants and 24 regulatory authorities.

Total Annual Burden Hours: 39,224.

Total Annual Non-Wage Cost Burden: $100,500.

Obligation to Respond: Required in order to obtain or retain benefits.

Send comments on the need for the collection of information for the performance of the functions of the agency; the accuracy of the agency's burden estimates; ways to enhance the quality, utility and clarity of the information collection; and ways to minimize the information collection burden on respondents, such as use of automated means of collection of the information, to the places listed in **ADDRESSES**. Please refer to control number 1029–0115 in all correspondence.

Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Dated: March 2, 2016.

John A. Trelease,

Acting Chief, Division of Regulatory Support.

[FR Doc. 2016–05145 Filed 3–7–16; 8:45 am]

BILLING CODE 4310–05–P

INTERNATIONAL TRADE COMMISSION

Notice of Appointment of Individuals To Serve as Members of the Performance Review Board

AGENCY: United States International Trade Commission.

ACTION: Appointment of Individuals to Serve as Members of Performance Review Board.

DATES: *Effective Date:* March 3, 2016.

SUMMARY: The Chairman of the U.S. International Trade Commission has appointed the following individuals to serve on the Commission's Performance Review Board (PRB):

Chair of the PRB: Vice Chairman Dean A. Pinkert
Vice-Chair of the PRB: Commissioner David Johanson
Member—Kirit Amin
Member—John Ascienzo
Member—Michael Anderson
Member—Dominic Bianchi
Member—Catherine DeFilippo
Member—James Holbein
Member—Margaret Macdonald
Member—Stephen A. McLaughlin
Member—William Powers
Member—Lyn M Schlitt

FOR FURTHER INFORMATION CONTACT: Eric Mozie, Director of Human Resources, U.S. International Trade Commission (202) 205–2651.

Authority: This notice is published in the **Federal Register** pursuant to the requirement of 5 U.S.C. 4314(c)(4). Hearing impaired individuals are advised that information on this matter can be obtained by contacting our TDD terminal on (202) 205–1810.

By order of the Chairman.

Issued: March 3, 2016.

Lisa R. Barton,

Secretary to the Commission.

[FR Doc. 2016–05114 Filed 3–7–16; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

[OMB Number 1105–0030]

Agency Information Collection Activities; Proposed eCollection eComments Requested; Revision of and Renewal of Previously Approved Collection; Comments Requested: Electronic Applications for the Attorney General's Honors Program and the Summer Law Intern Program

AGENCY: Office of Attorney Recruitment and Management, Department of Justice.

ACTION: 60-Day notice.

SUMMARY: The Department of Justice (DOJ), Justice Management Division, Office of Attorney Recruitment and Management (OARM), will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995.

DATES: Comments are encouraged and will be accepted for 60 days until May 9, 2016.

SUPPLEMENTARY INFORMATION: Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the U.S. Department of Justice, Office of Attorney Recruitment and Management, 450 5th Street NW., Suite 10200, Attn: Deana Willis, Washington, DC 20530. Your comments should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or

other forms of information technology, *e.g.,* permitting electronic submission of responses.

Overview of this information collection:

(1) Type of information collection: Minor Revision and Renewal of a Currently Approved Collection.

(2) The title of the form/collection: Electronic Applications for the Attorney General's Honors Program and the Summer Law Intern Program.

(3) The agency form number, if any, and the applicable component of the department sponsoring the collection: Form Number: none. Office of Attorney Recruitment and Management, Justice Management Division, U.S. Department of Justice.

(4) Affected public who will be asked or required to respond, as well as a brief abstract: Primary: Individuals or households. Other: None. The application form is submitted voluntarily, once a year by law students and recent law school graduates (*e.g.,* judicial law clerks) who will be in this applicant pool only once.

(5) An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond/reply: It is estimated that 4000 respondents will complete the application in approximately 1 hour per application, plus an estimated 600 respondents (candidates selected for interviews) who will complete a travel survey used to schedule interviews and prepare official Travel Authorizations prior to the interviewees' performing pre-employment interview travel (as defined by 41 CFR Sec. 301–1.3), as needed, in approximately 10 minutes per form, plus an estimated 400 respondents who will complete a Reimbursement Form (if applicable) in order for the Department to prepare the Travel Vouchers required to reimbursed candidates for authorized costs they incurred during pre-employment interview travel at approximately 10 minutes per form.

(6) An estimate of the total public burden (in hours) associated with the collection: The estimated revised total annual public burden associated with this application is 4167 hours.

If additional information is required, please contact: Jerri Murray, Department Clearance Officer, U.S. Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street NE., Room 3E.405B, Washington, DC 20530.

Dated: March 3, 2016.

Jerri Murray,

Department Clearance Officer for PRA, U.S. Department of Justice.

[FR Doc. 2016–05082 Filed 3–7–16; 8:45 am]

BILLING CODE 4410–PB–P

DEPARTMENT OF JUSTICE

Agency Information Collection Activities; Proposed eCollection; eComments Requested; Application for Cancellation of Removal (42A) for Certain Permanent Residents; and Application for Cancellation of Removal and Adjustment of Status (42B) for Certain Nonpermanent Residents (OMB 1125–0001)

AGENCY: Executive Office for Immigration Review, Department of Justice

ACTION: 60-day notice.

SUMMARY: The Department of Justice (DOJ), Executive Office for Immigration Review, will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995.

DATES: Comments are encouraged and will be accepted for 60 days until May 9, 2016.

FOR FURTHER INFORMATION CONTACT: If you have additional comments especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Jean King, General Counsel, Executive Office for Immigration Review, U.S. Department of Justice, Suite 2600, 5107 Leesburg Pike, Falls Church, Virginia 22041; telephone: (703) 305–0470.

SUPPLEMENTARY INFORMATION: Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Executive Office for Immigration Review, including whether the information will have practical utility;

—Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

—Evaluate whether and if so how the quality, utility, and clarity of the information to be collected can be enhanced; and

—Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Overview of this information collection:

1. *Type of Information Collection:* Extension of a currently approved collection.

2. *The Title of the Form/Collection:* Application for Cancellation of Removal for Certain Permanent Residents; and Application for Cancellation of Removal and Adjustment of Status for Certain Nonpermanent Residents.

3. *The agency form number, if any, and the applicable component of the Department sponsoring the collection:* The form numbers are EOIR–42A and EOIR–42B, Executive Office for Immigration Review, United States Department of Justice.

4. *Affected public who will be asked or required to respond, as well as a brief abstract:* Individual aliens determined to be removable from the United States. This information collection is necessary to determine the statutory eligibility of individual aliens who have been determined to be removable from the United States for cancellation of their removal, as well as to provide information relevant to a favorable exercise of discretion.

5. *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* It is estimated that 25,654 respondents will complete the form annually with an average of 5 hours, 50 minutes per response.

6. *An estimate of the total public burden (in hours) associated with the collection:* There are an estimated 148,793 total annual burden hours associated with this collection.

If additional information is required contact: Jerri Murray, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street NE., 3E.405B, Washington, DC 20530.

Dated: March 3, 2016.

Jerri Murray,

Department Clearance Officer for PRA, U.S. Department of Justice.

[FR Doc. 2016–05126 Filed 3–7–16; 8:45 am]

BILLING CODE 4410–30–P

DEPARTMENT OF LABOR

Office of the Secretary

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Statement of Expenditures and Financial Adjustments of Federal Funds for Unemployment Compensation for Federal Employees and Ex-Servicemembers

ACTION: Notice.

SUMMARY: The Department of Labor (DOL) is submitting the Employment and Training Administration (ETA) sponsored information collection request (ICR) titled, ''Statement of Expenditures and Financial Adjustments of Federal Funds for Unemployment Compensation for Federal Employees and Ex-Servicemembers,'' to the Office of Management and Budget (OMB) for review and approval for continued use, without change, in accordance with the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 *et seq.* Public comments on the ICR are invited.

DATES: The OMB will consider all written comments that agency receives on or before April 7, 2016.

ADDRESSES: A copy of this ICR with applicable supporting documentation; including a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained free of charge from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201510-1205-009* (this link will only become active on the day following publication of this notice) or by contacting Michel Smyth by telephone at 202–693–4129, TTY 202–693–8064, (these are not toll-free numbers) or by email at *DOL_PRA_PUBLIC@dol.gov.*

Submit comments about this request by mail or courier to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for DOL–ETA, Office of Management and Budget, Room 10235, 725 17th Street NW., Washington, DC 20503; by Fax: 202–395–5806 (this is not a toll-free number); or by email: *OIRA_submission@omb.eop.gov.* Commenters are encouraged, but not required, to send a courtesy copy of any comments by mail or courier to the U.S. Department of Labor—OASAM, Office of the Chief Information Officer, Attn: Departmental Information Compliance Management Program, Room N1301, 200 Constitution Avenue NW., Washington, DC 20210; or by email: *DOL_PRA_PUBLIC@dol.gov.*

FOR FURTHER INFORMATION CONTACT: Michel Smyth by telephone at 202–693–4129, TTY 202–693–8064, (these are not toll-free numbers) or by email at *DOL_PRA_PUBLIC@dol.gov.*

SUPPLEMENTARY INFORMATION: This ICR seeks to extend PRA authority for the Statement of Expenditures and Financial Adjustments of Federal Funds for Unemployment Compensation for Federal Employees and Ex-Servicemembers information collection. Federal civilian and military agencies must reimburse the Federal Employees Compensation Account for the amount expended for benefits to former Federal civilian employees and ex-servicemembers. Reporting Form ETA–191 informs the ETA of the amount to bill such agencies. Social Security Act section 303(a)(6) authorizes this information collection. *See* 5 U.S.C. 503(a)(6).

This information collection is subject to the PRA. A Federal agency generally cannot conduct or sponsor a collection of information, and the public is generally not required to respond to an information collection, unless it is approved by the OMB under the PRA and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person shall generally be subject to penalty for failing to comply with a collection of information that does not display a valid Control Number. *See* 5 CFR 1320.5(a) and 1320.6. The DOL obtains OMB approval for this information collection under Control Number 1205–0162.

OMB authorization for an ICR cannot be for more than three (3) years without renewal, and the current approval for this collection is scheduled to expire on March 31, 2016. The DOL seeks to extend PRA authorization for this information collection for three (3) more years, without any change to existing requirements. The DOL notes that existing information collection requirements submitted to the OMB receive a month-to-month extension while they undergo review. For additional substantive information about this ICR, see the related notice published in the **Federal Register** on August 26, 2016 (80 FR 51843).

Interested parties are encouraged to send comments to the OMB, Office of Information and Regulatory Affairs at the address shown in the **ADDRESSES** section within thirty (30) days of publication of this notice in the **Federal Register**. In order to help ensure appropriate consideration, comments should mention OMB Control Number 1205–0162. The OMB is particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Agency: DOL–ETA.

Title of Collection: Statement of Expenditures and Financial Adjustments of Federal Funds for Unemployment Compensation for Federal Employees and Ex-Servicemembers.

OMB Control Number: 1205–0162.

Affected Public: State, Local, and Tribal Governments.

Total Estimated Number of Respondents: 53.

Total Estimated Number of Responses: 212.

Total Estimated Annual Time Burden: 1,272 hours.

Total Estimated Annual Other Costs Burden: $0.

Authority: 44 U.S.C. 3507(a)(1)(D).

Dated: March 2, 2016.

Michel Smyth,

Departmental Clearance Officer.

[FR Doc. 2016–05066 Filed 3–7–16; 8:45 am]

BILLING CODE 4510–FW–P

DEPARTMENT OF LABOR

Office of the Secretary

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Benefit Rights and Experience Report

ACTION: Notice.

SUMMARY: The Department of Labor (DOL) is submitting the Employment and Training Administration (ETA) sponsored information collection request (ICR) revision titled, ''Benefit Rights and Experience Report,'' to the Office of Management and Budget (OMB) for review and approval for use in accordance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501 *et seq.*). Public comments on the ICR are invited.

DATES: The OMB will consider all written comments that agency receives on or before April 7, 2016.

ADDRESSES: A copy of this ICR with applicable supporting documentation; including a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained free of charge from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201512-1205-002* (this link will only become active on the day following publication of this notice) or by contacting Michel Smyth by telephone at 202–693–4129, TTY 202–693–8064, (these are not toll-free numbers) or sending an email to *DOL_PRA_PUBLIC@dol.gov.*

Submit comments about this request by mail or courier to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for DOL–ETA, Office of Management and Budget, Room 10235, 725 17th Street NW., Washington, DC 20503; by Fax: 202–395–5806 (this is not a toll-free number); or by email: *OIRA_submission@omb.eop.gov.* Commenters are encouraged, but not required, to send a courtesy copy of any comments by mail or courier to the U.S. Department of Labor—OASAM, Office of the Chief Information Officer, Attn: Departmental Information Compliance Management Program, Room N1301, 200 Constitution Avenue NW., Washington, DC 20210; or by email: *DOL_PRA_PUBLIC@dol.gov.*

FOR FURTHER INFORMATION CONTACT: Contact Michel Smyth by telephone at 202–693–4129, TTY 202–693–8064, (these are not toll-free numbers) or sending an email to *DOL_PRA_PUBLIC@dol.gov.*

Authority: 44 U.S.C. 3507(a)(1)(D).

SUPPLEMENTARY INFORMATION: This ICR seeks approval under the PRA for revisions to the Benefit Rights and Experience Report, Form ETA–218, information collection. In order for an individual to be eligible for a State unemployment compensation program, the claimant must meet certain requirements that demonstrate attachment to the labor force. The vast majority of states use past wages for this purpose, however, a few States use actual weeks of work. A State reports information relative to this first test of eligibility—known as monetary eligibility—on Form ETA–218, which includes counts on number of individuals who were and were not monetarily eligible, those eligible for the maximum benefits, the number of newly eligible claimants categorized by potential duration, and the number of persons who exhausted benefits categorized by their actual duration. This information collection has been classified as a revision, because the Extended Unemployment Compensation program has ended; therefore, maintaining the related information collection requirements no longer has practical utility. Social Security Act section 303(a)(6) authorizes this information collection. *See* 42 U.S.C. 503(a)(6).

This information collection is subject to the PRA. A Federal agency generally cannot conduct or sponsor a collection of information, and the public is generally not required to respond to an information collection, unless it is approved by the OMB under the PRA and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person shall generally be subject to penalty for failing to comply with a collection of information that does not display a valid Control Number. *See* 5 CFR 1320.5(a) and 1320.6. The DOL obtains OMB approval for this information collection under Control Number 1205–0177. The current approval is scheduled to expire on May 31, 2016; however, the DOL notes that existing information collection requirements submitted to the OMB receive a month-to-month extension while they undergo review. New requirements would only take effect upon OMB approval. For additional substantive information about this ICR, see the related notice published in the **Federal Register** on September 28, 2015 (80 FR 58299).

Interested parties are encouraged to send comments to the OMB, Office of Information and Regulatory Affairs at the address shown in the **ADDRESSES** section within thirty (30) days of publication of this notice in the **Federal Register**. In order to help ensure appropriate consideration, comments should mention OMB Control Number 1205–0177. The OMB is particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Agency: DOL–ETA.

Title of Collection: Benefit Rights and Experience Report.

OMB Control Number: 1205–0177.

Affected Public: State, Local, and Tribal Governments.

Total Estimated Number of Respondents: 55.

Total Estimated Number of Responses: 216.

Total Estimated Annual Time Burden: 108 hours.

Total Estimated Annual Other Costs Burden: $0.

Dated: March 2, 2016.

Michel Smyth,

Departmental Clearance Officer.

[FR Doc. 2016–05067 Filed 3–7–16; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Office of Workers' Compensation Programs

Proposed Extension of Existing Collections; Comment Request

AGENCY: Office of Workers' Compensation Programs, Labor.

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed

and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA95) [44 U.S.C. 3506(c)(2)(A)]. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Office of Workers' Compensation Programs is soliciting comments concerning the proposed collection: Claim for Compensation by Dependents Information Reports (CA–5, CA–5b, CA–1031, CA–1074, Letter of Compensation Due at Death, and Letter of Student/Dependency). A copy of the proposed information collection request can be obtained by contacting the office listed below in the addresses section of this Notice.

DATES: Written comments must be submitted to the office listed in the **ADDRESSES** section below on or before May 9, 2016.

ADDRESSES: Ms. Yoon Ferguson, U.S. Department of Labor, 200 Constitution Ave. NW., Room S–3323, Washington, DC 20210, telephone/fax (202) 354–9647, Email *ferguson.yoon@dol.gov.* Please use only one method of transmission for comments (mail, fax, or Email).

SUPPLEMENTARY INFORMATION:

I. Background

The forms included in this package are forms used by Federal employees and their dependents to claim benefits, to prove continued eligibility for benefits, to show entitlement to remaining compensation payments of a deceased employee and to show dependency under the Federal Employees' Compensation Act. There are six items in this information collection request. The information collected by Forms CA–5, is used by dependents for claiming compensation for the work related death of a Federal Employee and CA–5b is used by other survivors. Form CA–1031 is used in disability cases and provides information to determine whether a claimant is actually supporting a dependent and is entitled to additional compensation. Form CA–1074 is a follow up to CA–5b to request clarification of any information that is unclear and incomplete in the CA–5b. The letter of ''Compensation Due at Death'' is used to request information necessary to distribute compensation due when an employee dies who was receiving or who was entitled to compensation at the time of death for either disability benefits or a scheduled award. The letter of ''Student/Dependency'' is used to obtain information regarding the student status of a dependent. When a child reaches 18 years of age, they are no longer considered an eligible dependent unless they are a full time student or incapable of self-support. This information collection is currently approved for use through August 31, 2016.

II. Review Focus

The Department of Labor is particularly interested in comments which:

* Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

* evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

* enhance the quality, utility and clarity of the information to be collected; and

* minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

III. Current Actions

The Department of Labor seeks extension of approval to collect this information in order to carry out its responsibility to meet the statutory requirements of the Federal Employees' Compensation Act. The information contained in these forms is used by the Division of Federal Employees' Compensation to determine entitlement to benefits under the Act, to verify dependent status, and to initiate, continue, adjust, or terminate benefits based on eligibility criteria.

Type of Review: Extension.

Agency: Office of Workers' Compensation Programs.

Title: Claim for Compensation by Dependents Information Reports.

OMB Number: 1240–0013.

Agency Number: CA–5, CA–5b, CA–1031, CA–1074, Letter of Compensation Due at Death, and Letter of Student/Dependency.

Affected Public: Individuals or households.

Total Respondents: 1,675.

Total Responses: 1,675.

Form/Letter	Time to complete (min)	Frequency of response	Number of respondents	Hours burden
CA–5	90	1	129	194
CA–5b	90	1	7	11
CA–1031	20	1	83	28
CA–1074	60	1	5	5
Student Dependency	30	1	1,111	556
Comp Due at Death	30	1	340	170
Totals			1,675	964

Estimated Total Burden Hours: 964.

Total Burden Cost (capital/startup): $0.

Total Burden Cost (operating/maintenance): $871.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: March 3, 2016.

Yoon Ferguson,

Agency Clearance Officer, Office of Workers' Compensation Programs U.S. Department of Labor.

[FR Doc. 2016–05143 Filed 3–7–16; 8:45 am]

BILLING CODE 4510–CH–P

NATIONAL CREDIT UNION ADMINISTRATION

Agency Information Collection Activities: Proposed Collection; Comment Request; Corporate Credit Unions

AGENCY: National Credit Union Administration (NCUA).

ACTION: Notice and request for comments.

SUMMARY: The NCUA, as part of its continuing efforts to reduce paperwork and respondent burden, invites the general public and other Federal agencies to comment on a reinstatement of a previously approved collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). The NCUA is soliciting comments concerning regulations on corporate credit unions under 12 CFR part 704.

DATES: Written comments should be received on or before May 9, 2016 to be assured of consideration.

ADDRESSES: Interested persons are invited to submit comments to Dawn Wolfgang, National Credit Union Administration, 1775 Duke Street, Alexandria, Virginia 22314–3428, Fax No. 703–837–2861, or Email at *OCIOPRA@ncua.gov.*

FOR FURTHER INFORMATION CONTACT: Requests for additional information should be directed to the address above.

SUPPLEMENTARY INFORMATION:

OMB Number: 3133–0129.

Title: 12 CFR part 704, Corporate Credit Unions.

Abstract: Part 704 of NCUA's regulations established the regulatory framework for corporate credit unions. This includes various reporting and recordkeeping requirements as well as safety and soundness standards. NCUA has established and regulates corporate credit unions pursuant to its authority under sections 120, 201, and 209 of the Federal Credit Union Act, 12 U.S.C. 1766(a), 1781, and 1789. The collection of information is necessary to ensure that corporate credit unions operate in a safe and sound manner by limiting risk to their natural person credit union members and the National Credit Union Share Insurance Fund.

Part 704 includes the following information collection requirements: Retained Earnings Accumulation Plan (§ 704.3(a)(3)); Notice of Intent to Redeem or Call Contributed Capital (§§ 704.3(b)(5) and (c)(3)); Notice of PCA Category Change (§ 704.4(c)(2)); Capital Restoration Plan (§ 704.4(e)); ALM Testing (§ 704.8(j)); Investment Action Plan (§ 704.10); Disclosure of Dual Employee Compensation Received from Corporate Credit Union Service Organization (Corporate CUSO) (§ 704.11(g)); Corporate CUSO Approval Request (§ 704.11(e)); Recorded Director Votes (§ 704.13(c)(8)); Management Report (§ 704.15(a)(2)); Notice of Engagement or Termination of Accountants (§ 704.15(c)(4)); Notification of Late Filing (§ 704.15(c)(5)); Disclosure of Executive Compensation (§ 704.19), and Merger-Related Disclosures (§ 704.19(d)).

Type of Review: Reinstatement with change of a previously approved collection.

Affected Public: Federal and state-chartered corporate credit unions.

Estimated No. of Respondents/Recordkeepers: 12.

Estimated No. of Responses: 200.

Estimated No. of Responses per Respondent: 17.

Estimated Hours per Response: 2.4.

Estimated Total Annual Burden Hours: 483.

Reason for Change: The burden has decreased from the previous submission primarily due to a decrease in the number of corporate credit unions from 27 to 12. However, the remaining corporate credit unions tend to be more complex and approved for expanded authorities. Additional burden reductions are attributed information collection elements not adopted, eliminated, or moved by rulemaking.

Request for Comments: Comments submitted in response to this notice will be summarized and included in the request for Office of Management and Budget approval. All comments will become a matter of public record. The public is invited to submit comments concerning: (a) Whether the collection of information is necessary for the proper performance of the function of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of the information collection, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including the use of automated collection techniques or other forms of information technology.

By Gerard Poliquin, Secretary of the Board, the National Credit Union Administration, on March 2, 2016.

Dated: March 2, 2016.

Dawn D. Wolfgang,

NCUA PRA Clearance Officer.

[FR Doc. 2016–05010 Filed 3–7–16; 8:45 am]

BILLING CODE 7535–01–P

NATIONAL SCIENCE FOUNDATION

Sunshine Act Meetings; National Science Board

The National Science Board's Committee on Strategy and Budget, Subcommittee on Facilities (SCF), pursuant to NSF regulations (45 CFR part 614), the National Science Foundation Act, as amended (42 U.S.C. 1862n–5), and the Government in the Sunshine Act (5 U.S.C. 552b), hereby gives notice of the scheduling of a teleconference for the transaction of National Science Board business, as follows:

TIME AND DATE: Friday, March 11, 2016 at 11:30 to 12:30 p.m. EST. Open session: 11:30 to 12:05 p.m.; closed session: 12:05 to 12:30 p.m.

PLACE: This meeting will be held by teleconference. A public listening line will be available for the open portion of the meeting. Members of the public must contact the Board Office [call 703–292–7000 or send an email message to *nationalsciencebrd@nsf.gov*] at least 24 hours prior to the teleconference for the public listening number. Please refer to the National Science Board Web site for additional information and schedule updates (time, place, subject matter or status of meeting) which may be found at *http://www.nsf.gov/nsb/notices/.*

STATUS: Partly open, partly closed.

MATTERS TO BE CONSIDERED:

Open meeting subjects: Chairman's remarks; planning for 2016 Annual Portfolio Review and white papers, and discussion of facility synopses.

Closed meeting subject: Discussion of LFO monthly facility reports.

CONTACT PERSON FOR MORE INFORMATION: The point of contact for this meeting is John Veysey, *jveysey@nsf.gov*).

Kyscha Slater-Williams,

Program Specialist.

[FR Doc. 2016–05246 Filed 3–4–16; 4:15 pm]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–369 and 50–370; NRC–2016–0049]

Duke Energy Carolinas, LLC, McGuire Nuclear Station, Units 1 and 2; Environmental Assessment and Finding of No Significant Impact

AGENCY: Nuclear Regulatory Commission.

ACTION: Environmental assessment and finding of no significant impact; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is considering issuance of an exemption for Facility Operating License Nos. NPF–9 and NPF–17, issued to Duke Energy Carolinas, LLC (Duke, the licensee) for operation of McGuire Nuclear Station, Units 1 and 2 (McGuire), located near Huntersville, North Carolina. The licensee requested an exemption from certain physical inventory requirements because the inventory items are no longer in service and are not readily accessible. The NRC prepared an environmental assessment (EA) documenting its finding. The NRC concluded that the proposed actions will have no significant environmental impact. Accordingly, the NRC staff is issuing its final EA and a final finding of no significant impact (FONSI) associated with the proposed exemption.

DATES: The environmental assessment referenced in this document is available on March 8, 2016.

ADDRESSES: Please refer to Docket ID NRC–2016–0049 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2016–0049. Address questions about NRC dockets to Carol Gallagher; telephone: 301–415–3463; email: *Carol.Gallagher@nrc.gov.*
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents''* and then select ''*Begin Web-based ADAMS Search.''* For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced (if that document is available in ADAMS) is provided the first time that a document is referenced.
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: G. Edward Miller, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington DC 20555–0001; telephone: 301–415–2481, email: *Ed.Miller@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The NRC is considering issuance of an exemption from section 74.19(c) of title 10 of the *Code of Federal Regulations* (10 CFR), for Facility Operating License Nos. NPF–9 and NPF–17, issued to Duke for operation of McGuire, located near Huntersville, North Carolina. Consistent with 10 CFR 51.21, the NRC has reviewed the requirements in 10 CFR 51.20(b) and 10 CFR 51.22(c) and determined that an EA is the appropriate form of environmental review for the requested action. In accordance with 10 CFR 51.21, the NRC prepared an EA documenting its finding. Based on the results of the EA, the NRC concluded that the proposed actions will have no significant environmental impact and is issuing this final FONSI.

II. Environmental Assessment

Description of the Proposed Action

The regulation in 10 CFR 74.19(c) requires, in part, ''Other than licensees subject to sections 74.31, 74.33, 74.41, or 74.51, each licensee who is authorized to possess special nuclear material, at any one time and site location, in a quantity greater than 350 grams of contained uranium-235, uranium-233, or plutonium, or any combination thereof, shall conduct a physical inventory of all special nuclear material in its possession under license at intervals not to exceed 12 months.'' By application dated August 17, 2015, as supplemented by letter dated October 6, 2015 (ADAMS Accession Nos. ML15239B240 and ML15300A282, respectively), the licensee requested an exemption from certain recordkeeping requirements in 10 CFR 74.19(c).

Specifically, the licensee requested an exemption for conducting a physical inventory of the moveable incore detectors in their Moveable Incore Detector (MIDS) system. The moveable incore detectors are no longer in service and are stored in a location where they are not readily accessible except during plant outages.

Need for the Proposed Action

The proposed exemption to the recordkeeping requirements of 10 CFR 74.19(c) is needed to grant the licensee relief from the physical inventory requirements for the movable incore detectors in their MIDS system, which contain special nuclear material and are required to be listed on their physical inventory. The licensee states that the moveable incore detectors have been removed from service and are stored inside shielded storage pipes (sleeves) located inside the reactor buildings concrete inner shield wall, making them physically inaccessible. The licensee also states that modifications are being made to ensure that the moveable incore detectors meet the requirements of inaccessibility. The modifications involve installing tamper-evident seals to ensure the incore detectors are not accessed and the seals will be verified every outage.

Environmental Impacts of the Proposed Action

The NRC has completed its evaluation of the proposed action and concludes that the proposed exemption would not significantly increase the probability or consequences of accidents. No changes would be made in the types of effluents that may be released offsite. There would be no significant increase in the amount of any effluent released offsite. There would be no significant increase in occupational or public radiation exposure. Therefore, there would be no significant radiological environmental impacts associated with the proposed action.

With regard to potential non-radiological impacts, the proposed action would not have any foreseeable impacts to land, air, or water resources, including impacts to biota. In addition, there are also no known socioeconomic or environmental justice impacts associated with such proposed action. Therefore, there are no significant non-radiological environmental impacts associated with the proposed action.

Accordingly, the NRC concludes that there are no significant environmental impacts associated with the proposed action.

Environmental Impacts of the Alternatives to the Proposed Action

As an alternative to the proposed actions, the NRC staff considered denial of the proposed action (*i.e.,* the ''no-action'' alternative). Denial of the exemption request would result in no

change in current environmental impacts. The environmental impacts of the proposed exemption and the ''no action'' alternative are similar.

Alternative Use of Resources

The action does not involve the use of any different resources than those previously considered in the ''Final Environmental Statement Related to the Operation of William B. McGuire Nuclear Station, Units 1 and 2,'' dated January, 1981, and NUREG–1437, Supplement 8, ''Generic Environmental Impact Statement for License Renewal of Nuclear Plants, Regarding McGuire Nuclear Station, Units 1 and 2, Final Report,'' dated December 2002 (ADAMS Accession No. ML030020184).

Agencies and Persons Consulted

The staff did not enter into consultation with any other Federal Agency or with the State of North Carolina regarding the environmental impact of the proposed action.

III. Finding of No Significant Impact

On the basis of the environmental assessment, the NRC concludes that the proposed exemption will not have a significant effect on the quality of the human environment. Accordingly, the NRC has determined not to prepare an environmental impact statement for the proposed action. Other than the licensee's letter dated August 17, 2015, and supplemented October 6, 2015, there are no other environmental documents associated with this review.

This document is available for public inspection as indicated above.

Dated at Rockville, Maryland, this 29th day of February 2016.

For the Nuclear Regulatory Commission.

G. Edward Miller,

Project Manager, Plant Licensing Branch II–1, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. 2016–05134 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 040–8964; NRC–2014–0092]

Power Resources, Inc.

AGENCY: Nuclear Regulatory Commission.

ACTION: Temporary exemption; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is issuing a temporary exemption from certain NRC financial assurance requirements to Power Resources, Inc., doing business as Cameco Resources (Cameco), in response to its annual financial assurance updates for its Smith Ranch-Highland *In-Situ* Recovery (ISR) project and the associated remote satellite facilities at Ruth and Gas Hills. Issuance of this temporary exemption will not remove the requirement for Cameco to provide adequate financial assurance through an approved mechanism but will allow the NRC staff to further evaluate whether the State of Wyoming's separate account provision for financial assurance instruments Cameco holds is consistent with the NRC's requirement for a standby trust agreement.

ADDRESSES: Please refer to Docket ID NRC–2014–0092 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2014–0092. Address questions about NRC dockets to Carol Gallagher; telephone: 301–415–3463; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents''* and then select ''*Begin Web-based ADAMS Search.''* For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced (if that document is available in ADAMS) is provided the first time that a document is referenced.
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: Douglas T. Mandeville, Office of Nuclear Material Safety and Safeguards; U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–0724; email: *Douglas.Mandeville@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Pursuant to part 40 of title 10 of the *Code of Federal Regulations* (10 CFR), appendix A, Criterion 9 and NRC Materials License SUA–1601, License Condition 9.5, Cameco is required to submit to the NRC for review and approval an annual update of the financial surety to cover third-party costs for decommissioning and decontamination of the Smith Ranch-Highland ISR facility and its associated remote satellites located in Converse, Johnson, Campbell, and Fremont Counties, Wyoming. By letter dated December 4, 2014, Cameco submitted its annual financial surety update to the NRC staff for the Ruth remote satellite facility (Cameco 2014). Additionally, Cameco submitted its annual surety updates for the Smith Ranch-Highland facility and the Gas Hills remote satellite facility on July 7, 2015, and August 7, 2015 respectively (Cameco 2015a and Cameco 2015b). The NRC staff reviewed the annual financial surety update and found the values reasonable for the required reclamation activities (ADAMS Accession No. ML15348A074). Cameco maintains approved financial assurance instruments in favor of the State of Wyoming; however, it does not have a standby trust agreement (STA) in place, as required by 10 CFR part 40, appendix A, Criterion 9.

II. Description of Action

As of December 17, 2012, NRC's uranium milling licensees, which are regulated, in part, under 10 CFR part 40, appendix A, Criterion 9, are required to have an STA in place. Criterion 9 provides that if a licensee does not use a trust as its financial assurance mechanism, then the licensee is required to establish a standby trust fund to receive funds in the event the Commission or State regulatory agency exercises its right to collect the funds provided for by surety bond or letter of credit. The purpose of an STA is to provide a separate account to hold the decommissioning funds in the event of a default.

Consistent with the provisions of 10 CFR part 40, appendix A, Criterion 9(d), Cameco has consolidated its NRC financial assurance sureties with those Cameco is required to obtain by the State of Wyoming, and the financial instrument is held by the State of Wyoming. Cameco has not established an STA, nor has it requested an exemption from the requirement to do so.

Wyoming law requires that a separate account be set up to receive forfeited decommissioning funds but does not specifically require an STA. Section 35–11–424(a) of the Code of Wyoming states that ''[a]ll forfeitures collected

under the provisions of this act shall be deposited with the State treasurer in a separate account for reclamation purposes.'' Under Wyoming Department of Environmental Quality (WDEQ) financial assurance requirements, WDEQ holds permit bonds in a fiduciary fund called an agency fund. If a bond is forfeited, the forfeited funds are moved to a special revenue account. Although the Wyoming special revenue account is not an STA, the special revenue account serves a similar purpose in that forfeited funds are not deposited into the State treasury for general fund use but instead are set aside in the special revenue account to be used exclusively for reclamation (*i.e.,* decommissioning purposes).

The NRC has the discretion, under 10 CFR 40.14(a), to grant an exemption from the requirements of a regulation in 10 CFR part 40 upon request or on its own initiative, if the NRC determines the exemption is authorized by law and will not endanger life or property or the common defense and security and is otherwise in the public interest. The NRC is issuing an exemption to Cameco from the STA requirements in 10 CFR part 40, appendix A, Criterion 9, for the current surety arrangement until March 26, 2017, for Ruth, September 30, 2017, for Smith Ranch-Highland, and November 7, 2017, for Gas Hills to allow the NRC an opportunity to evaluate whether the State of Wyoming's separate account requirements for financial assurance instruments it holds is consistent with the NRC's STA requirements.

III. Discussion

A. The Exemption Is Authorized by Law

The proposed exemption is authorized by law as 10 CFR 40.14(a) expressly allows for an exemption to the requirements in 10 CFR part 40, Appendix A, Criterion 9, and the proposed exemption would not be contrary to any provision of the Atomic Energy Act of 1954, as amended.

B. The Exemption Presents No Undue Risk to Public Health and Safety

The exemption is related to the financial surety. The requirement that the licensee provide adequate financial assurance through an approved mechanism (*e.g.,* a surety bond or an irrevocable letter of credit) would remain unaffected by the exemption. Rather, the exemption would only pertain to the establishment of a dedicated trust in which funds could be deposited in the event that the financial assurance mechanism needed to be liquidated. The requirement in 10 CFR part 40, Appendix A, Criterion 9(d), allows for the financial or surety arrangements to be consolidated within a State's similar financial assurance instrument. The NRC has determined that while the State of Wyoming does not require an STA, the special revenue account may serve a similar purpose in that forfeited funds are not deposited into the State treasury for general fund use but, instead, are set aside in the special revenue account to be used exclusively for site-specific reclamation (*i.e.,* decommissioning purposes). Because the licensee remains obligated to establish an adequate financial assurance mechanism for its licensed sites, and the NRC has approved such a mechanism, sufficient funds are available in the event that the site would need to be decommissioned. A temporary delay in establishing an STA does not impact the present availability and adequacy of the actual financial assurance mechanism. Therefore, the limited exemption being issued by the NRC herein presents no undue risk to public health and safety.

C. The Exemption Is Consistent With the Common Defense and Security

The proposed exemption would not involve or implicate the common defense or security. Therefore, granting the exemption will have no effect on the common defense and security.

D. The Exemption Is in the Public Interest

The proposed exemption would enable the NRC staff to evaluate the State of Wyoming's separate account provision and the NRC's STA requirement to determine if they are comparable. The evaluation process will allow the NRC to determine whether the licensee's compliance with the state law provision will satisfy the NRC requirement as well. Therefore, granting the exemption is in the public interest.

E. Environmental Considerations

The NRC staff has determined that granting of an exemption from the requirements of 10 CFR part 40, Appendix A, Criterion 9 belongs to a category of regulatory actions that the NRC, by regulation, has determined do not individually or cumulatively have a significant effect on the environment and, as such, do not require an environmental assessment. The exemption from the requirement to have an STA in place is eligible for categorical exclusion under 10 CFR 51.22(c)(25)(vi)(H), which provides that exemptions from surety, insurance, or indemnification requirements are categorically excluded if the exemption would not result in any significant hazards consideration, change or increase in the amount of any offsite effluents, increase in individual or cumulative public or occupational radiation exposure, construction impacts, or increase in the potential for or consequence from radiological accidents. The NRC staff finds that the STA exemption involves surety, insurance, and/or indemnity requirements and that granting Cameco this temporary exemption from the requirement of establishing a standby trust arrangement would not result in any significant hazards or increases in offsite effluents, radiation exposure, construction impacts, or potential radiological accidents. Therefore, an environmental assessment is not required.

IV. Conclusion

Accordingly, the NRC has determined that, pursuant to 10 CFR 40.14(a), the proposed temporary exemption is authorized by law, will not present an undue risk to the public health and safety, is consistent with the common defense and security, and is in the public interest. NRC hereby grants Power Resources, Inc., doing business as Cameco Resources, an exemption from the requirement in 10 CFR part 40, Appendix A, Criterion 9 to set up a standby trust to receive funds in the event the NRC or the State regulatory agency exercises is right to collect the surety. This exemption will expire on March 26, 2017, for Ruth, on September 30, 2017, for Smith Ranch-Highland, and on November 7, 2017, for Gas Hills.

Dated at Rockville, Maryland, this 29 day of February 2016.

For the Nuclear Regulatory Commission.

John R. Tappert,

Director, Division of Decommissioning, Uranium Recovery and Environmental Programs, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2016–05129 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 52–025 and 52–026; NRC–2008–0252]

Vogtle Electric Generating Station, Units 3 and 4; Southern Nuclear Operating Company; Control Rod Drive Mechanism Motor Generator Set Field Relay Change

AGENCY: Nuclear Regulatory Commission.

ACTION: Exemption and combined license amendment; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is granting an exemption to allow a departure from the certification information of Tier 1 of the generic design control document (DCD) and is issuing License Amendment No. 38 to Combined Licenses (COLs), NPF–91 and NPF–92. The COLs were issued to Southern Nuclear Operating Company, Inc., and Georgia Power Company, Oglethorpe Power Corporation, MEAG Power SPVM, LLC., MEAG Power SPVJ, LLC., MEAG POWER SPVP, LLC., and the City of Dalton, Georgia (together ''the licensees''); for construction and operation of the Vogtle Electric Generating Plant (VEGP) Units 3 and 4, located in Burke County, Georgia.

The granting of the exemption allows the changes to Tier 1 information asked for in the amendment. Because the acceptability of the exemption was determined in part by the acceptability of the amendment, the exemption and amendment are being issued concurrently.

DATES: March 8, 2016.

ADDRESSES: Please refer to Docket ID NRC–2008–0252 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

- Federal Rulemaking Web site: Go to *http://www.regulations.gov* and search for Docket ID NRC–2008–0252. Address questions about NRC dockets to Carol Gallagher; telephone: 301–415–3463; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- NRC's Agencywide Documents Access and Management System (ADAMS): You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''ADAMS Public Documents'' and then select ''*Begin Web-based ADAMS Search.*'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced (if it available in ADAMS) is provided the first time that a document is referenced. The request for the amendment and exemption was submitted by letter dated January 8, 2015 (ADAMS Accession No. ML15008A466).
- NRC's PDR: You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: Paul Kallan, Office of New Reactors, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–2809; email: *Paul.Kallan@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The NRC is granting an exemption from paragraph B of Section III, ''Scope and Contents,'' of Appendix D, ''Design Certification Rule for the AP1000,'' to part 52 of title 10 of the *Code of Federal Regulations* (10 CFR), and issuing License Amendment No. 38 to COLs, NPF–91 and NPF–92, to the licensee. The exemption is required by paragraph A.4 of Section VIII, ''Processes for Changes and Departures,'' Appendix D, to 10 CFR part 52 to allow the licensee to depart from Tier 1 information. With the requested amendment, the licensee sought proposed changes that specifies the use of latching control relays in lieu of breakers to de-energize the control rod drive mechanism (CRDM) motor generator (MG) set generator field on a diverse actuation system (DAS) reactor trip signal. The replacement of the CRDM MG set generator field breakers with field control relays requires a UFSAR Tier 2 departure that involves changes to COL Appendix C, Tables 2.5.1–4, ''Inspections, Tests, Analyses, and Acceptance Criteria,'' and 3.7–1, ''Risk-Significant Components,'' along with corresponding departures from plant-specific DCD Tier 1 information.

Part of the justification for granting the exemption was provided by the review of the amendment. Because the exemption is necessary in order to issue the requested license amendment, the NRC granted the exemption and issued the amendment concurrently, rather than in sequence. This included issuing a combined safety evaluation containing the NRC staff's review of both the exemption request and the license amendment. The exemption met all applicable regulatory criteria set forth in 10 CFR 50.12, 10 CFR 52.7, and Section VIII.A.4 of Appendix D to 10 CFR part 52. The license amendment was found to be acceptable as well. The combined safety evaluation is available in ADAMS under Accession No. ML15187A361.

Identical exemption documents (except for referenced unit numbers and license numbers) were issued to the licensee for VEGP Units 3 and 4 (COLs NPF–91 and NPF–92). The exemption documents for VEGP Units 3 and 4 can be found in ADAMS under Accession Nos. ML15187A297 and ML15187A325, respectively. The exemption is reproduced (with the exception of abbreviated titles and additional citations) in Section II of this document. The amendment documents for COLs NPF–91 and NPF–92 are available in ADAMS under Accession Nos. ML15187A281 and ML15187A285, respectively. A summary of the amendment documents is provided in Section III of this document.

II. Exemption

Reproduced below is the exemption document issued to Vogtle Units 3 and Unit 4. It makes reference to the combined safety evaluation that provides the reasoning for the findings made by the NRC (and listed under Item 1) in order to grant the exemption:

1. In a letter dated January 08, 2015, the licensee requested from the Commission an exemption from the provisions of 10 CFR part 52, Appendix D, Section III.B, as part of license amendment request 15–002, ''Control Rod Mechanism Motor Generator Set Field Relay Change (LAR–15–002).''

For the reasons set forth in Section 3.1, ''Evaluation of Exemption,'' of the NRC staff's Safety Evaluation, which can be found in ADAMS under Accession No. ML15187A361, the Commission finds that:

A. the exemption is authorized by law;

B. the exemption presents no undue risk to public health and safety;

C. the exemption is consistent with the common defense and security;

D. special circumstances are present in that the application of the rule in this circumstance is not necessary to serve the underlying purpose of the rule;

E. the special circumstances outweigh any decrease in safety that may result from the reduction in standardization caused by the exemption; and

F. the exemption will not result in a significant decrease in the level of safety otherwise provided by the design.

2. Accordingly, the licensee is granted an exemption from the certified DCD Tier 1, COL Appendix C, Table 2.5.1–4, and Table 3.7–1, as described in the licensee's request dated January 08, 2015. This exemption is related to, and necessary for the granting of License Amendment No. 38, which is being issued concurrently with this exemption.

3. As explained in Section 5.0, ''Environmental Consideration,'' of the NRC staff's Safety Evaluation (ADAMS

Accession No. ML15187A361), this exemption meets the eligibility criteria for categorical exclusion set forth in 10 CFR 51.22(c)(9). Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment needs to be prepared in connection with the issuance of the exemption.

4. This exemption is effective as of September 8, 2015.

III. License Amendment Request

By letter dated January 8, 2015, the licensee requested that the NRC amend the COLs for VEGP, Units 3 and 4, COLs NPF–91 and NPF–92. The proposed amendment is described in Section I of this **Federal Register** notice.

The Commission has determined for these amendments that the application complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

A notice of consideration of issuance of amendment to facility operating license or combined license, as applicable, proposed no significant hazards consideration determination, and opportunity for a hearing in connection with these actions, was published in the **Federal Register** on February 3, 2015 (80 FR 5798). No comments were received during the 30-day comment period.

The Commission has determined that these amendments satisfy the criteria for categorical exclusion in accordance with 10 CFR 51.22. Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment need be prepared for these amendments.

IV. Conclusion

Using the reasons set forth in the combined safety evaluation, the staff granted the exemption and issued the amendment that the licensee requested on January 8, 2015. The exemption and amendment were issued on September 8, 2015, as part of a combined package to the licensee (ADAMS Accession No. ML15187A258).

Dated at Rockville, Maryland, this 1st day of March 2016.

For the Nuclear Regulatory Commission.

John McKirgan,

Acting Chief, Licensing Branch 4, Division of New Reactor Licensing, Office of New Reactors.

[FR Doc. 2016–05133 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Reactor Safeguards (ACRS); Meeting of the ACRS Subcommittee on Metallurgy and Reactor Fuels

The ACRS Subcommittee on Metallurgy & Reactor Fuels will hold a meeting on March 22, 2016, Room T–2B1, 11545 Rockville Pike, Rockville, Maryland.

The meeting will be open to public attendance.

The agenda for the subject meeting shall be as follows:

Tuesday, March 22, 2016—8:30 a.m. until 12:00 p.m.

The Subcommittee will discuss Regulatory Guide 1.229, ''Risk-Informed Approach for Addressing the Effects of Debris on Post-Accident Long-Term Core Cooling.'' The Subcommittee will hear presentations by and hold discussions with the NRC staff and other interested persons regarding this matter. The Subcommittee will gather information, analyze relevant issues and facts, and formulate proposed positions and actions, as appropriate, for deliberation by the Full Committee.

Members of the public desiring to provide oral statements and/or written comments should notify the Designated Federal Official (DFO), Christopher Brown (Telephone 301–415–7111 or Email: *Christopher.Brown@nrc.gov*) five days prior to the meeting, if possible, so that appropriate arrangements can be made. Thirty-five hard copies of each presentation or handout should be provided to the DFO thirty minutes before the meeting. In addition, one electronic copy of each presentation should be emailed to the DFO one day before the meeting. If an electronic copy cannot be provided within this timeframe, presenters should provide the DFO with a CD containing each presentation at least thirty minutes before the meeting. Electronic recordings will be permitted only during those portions of the meeting that are open to the public. Detailed procedures for the conduct of and participation in ACRS meetings were published in the **Federal Register** on October 21, 2015, (80 FR 63846).

Detailed meeting agendas and meeting transcripts are available on the NRC Web site at *http://www.nrc.gov/reading-rm/doc-collections/acrs.* Information regarding topics to be discussed, changes to the agenda, whether the meeting has been canceled or rescheduled, and the time allotted to present oral statements can be obtained from the Web site cited above or by contacting the identified DFO. Moreover, in view of the possibility that the schedule for ACRS meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should check with these references if such rescheduling would result in a major inconvenience.

If attending this meeting, please enter through the One White Flint North building, 11555 Rockville Pike, Rockville, MD. After registering with security, please contact Mr. Theron Brown (Telephone 240–888–9835) to be escorted to the meeting room.

Dated: March 2, 2016.

Mark L. Banks,

Chief, Technical Support Branch, Advisory Committee on Reactor Safeguards.

[FR Doc. 2016–05135 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Reactor Safeguards (ACRS), Meeting of the ACRS Subcommittee on Metallurgy & Reactor Fuels, Notice of Meeting

The ACRS Subcommittee on Metallurgy & Reactor Fuels will hold a meeting on March 23–24, 2016, Room T–2B1, 11545 Rockville Pike, Rockville, Maryland.

The meeting will be open to public attendance.

The agenda for the subject meeting shall be as follows:

Wednesday, March 23, 2016—8:30 a.m. Until 5:00 p.m.; Thursday, March 24, 2016, 8:30 a.m. Until 12:00 p.m.

The Subcommittee will discuss framework for Storage and Transportation of Spent Fuel. The Subcommittee will hear presentations by and hold discussions with the NRC staff and other interested persons regarding this matter. The Subcommittee will gather information, analyze relevant issues and facts, and formulate proposed positions and actions, as appropriate, for deliberation by the Full Committee.

Members of the public desiring to provide oral statements and/or written comments should notify the Designated Federal Official (DFO), Christopher Brown (Telephone 301–415–7111 or Email: *Christopher.Brown@nrc.gov*) five days prior to the meeting, if possible, so that appropriate arrangements can be made. Thirty-five hard copies of each presentation or handout should be provided to the DFO thirty minutes

before the meeting. In addition, one electronic copy of each presentation should be emailed to the DFO one day before the meeting. If an electronic copy cannot be provided within this timeframe, presenters should provide the DFO with a CD containing each presentation at least thirty minutes before the meeting. Electronic recordings will be permitted only during those portions of the meeting that are open to the public. Detailed procedures for the conduct of and participation in ACRS meetings were published in the **Federal Register** on October 21, 2015, (80 FR 63846).

Detailed meeting agendas and meeting transcripts are available on the NRC Web site at *http://www.nrc.gov/reading-rm/doc-collections/acrs.* Information regarding topics to be discussed, changes to the agenda, whether the meeting has been canceled or rescheduled, and the time allotted to present oral statements can be obtained from the Web site cited above or by contacting the identified DFO. Moreover, in view of the possibility that the schedule for ACRS meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should check with these references if such rescheduling would result in a major inconvenience.

If attending this meeting, please enter through the One White Flint North building, 11555 Rockville Pike, Rockville, MD. After registering with security, please contact Mr. Theron Brown (Telephone 240–888–9835) to be escorted to the meeting room.

Dated: March 2, 2016.

Mark L. Banks,

Chief, Technical Support Branch, Advisory Committee on Reactor Safeguards.

[FR Doc. 2016–05137 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 52–027 and 52–028; NRC–2008–0441]

Virgil C. Summer Nuclear Station, Units 2 and 3; South Carolina Electric and Gas; Reclassification of Tier 2* Information on Fire Area Figures

AGENCY: Nuclear Regulatory Commission.

ACTION: Exemption and combined license amendment; issuance.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is granting an exemption from certain Tier 2* information in the generic design control document (DCD) and issuing License Amendment No. 40 to Combined Licenses (COL), NPF–93 and NPF–94. The COLs were issued to South Carolina Electric and Gas (SCE&G) and South Carolina Public Service Authority (Santee Cooper) (the licensee), for construction and operation of the Virgil C. Summer Nuclear Station (VCSNS), Units 2 and 3 located in Fairfield County, South Carolina.

The granting of the exemption allows the changes to Tier 2* information requested in the amendment. Because the acceptability of the exemption was determined in part by the acceptability of the amendment, the exemption and amendment are being issued concurrently.

DATES: March 8, 2016.

ADDRESSES: Please refer to Docket ID NRC–2008–0441 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2008–0441. Address questions about NRC dockets to Carol Gallagher; telephone: 301–415–3463; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''ADAMS Public Documents'' and then select *''Begin Web-based ADAMS Search.''* For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced (if it available in ADAMS) is provided the first time that a document is referenced. The request for the amendment and exemption were submitted by letter dated May 4, 2015 (ADAMS Accession No. ML15124A911).
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: Billy Gleaves, Office of New Reactors, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–5848; email: *Bill.Gleaves@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The NRC is granting an exemption from Section VIII.B.6.b, Item (4), ''Processes for Changes and Departures,'' of appendix D, ''Design Certification Rule for the AP1000,'' to part 52 of title 10 of the *Code of Federal Regulations* (10 CFR), and issuing License Amendment No. 40 to COLs, NPF–93 and NPF–94, to the licensee. The exemption is required by paragraph VIII.B.6.b of Section VIII, ''Processes for Changes and Departures,'' appendix D to 10 CFR part 52 to allow the licensee to change the designation of Tier 2* information. Specifically, with the requested amendment, the licensee sought to redesignate the Fire Area Figures, designated as Tier 2* in appendix D, as Tier 2. This requires an exemption, rather than the departure that would be required for changes to the figures that preserve the Tier 2* designation, because it has been established that departures do not alter the change control process applicable to specific sections of a design certification rule.

Part of the justification for granting the exemption was provided by the review of the amendment. Because the exemption is necessary in order to issue the requested license amendment, the NRC granted the exemption and issued the amendment concurrently, rather than in sequence. This included issuing a combined safety evaluation containing the NRC staff's review of both the exemption request and the license amendment. The exemption met all applicable regulatory criteria set forth in 10 CFR 50.12, 10 CFR 52.7, and 10 CFR 52.63(b)(1) of appendix D to 10 CFR part 52. The license amendment was found to be acceptable as well. The combined safety evaluation is available in ADAMS under Accession No. ML15328A276.

Identical exemption documents (except as needed to reflect the unique unit numbers and license numbers) were issued to the licensee for VCSNS Units 2 and 3 (COLs NPF–93 and NPF–94). These documents can be found in ADAMS under Accession Nos. ML15328A289 and ML15328A293, respectively. The exemption is reproduced (with the exception of abbreviated titles and additional citations) in Section II of this document. The amendment documents for COLs NPF–93 and NPF–94 are available in ADAMS under Accession Nos. ML15328A281 and ML15328A284, respectively. A summary of the

amendment documents is provided in Section III of this document.

II. Exemption

Reproduced below is the exemption document issued to VCSNS Units 2 and 3. It makes reference to the combined safety evaluation that provides the reasoning for the findings made by the NRC (and listed under Item 1) in order to grant the exemption:

1. In a letter dated May 4, 2015, the South Carolina Electric & Gas Company (SC&G/licensee) requested from the NRC an exemption from the provisions of part 50, appendix D of title 10 of the *Code of Federal Regulations* (10 CFR), ''Design Certification Rule for AP1000 Design,'' Section VIII.B.6.b, Item (4), to allow a departure from the certified information as part of license amendment request (LAR) 15–07, ''Request for License Amendment and Exemption: Reclassification of Tier 2* Information on Fire Area Figures.''

For the reasons set forth in Section 3.1 of the NRC staff's Safety Evaluation that supports this license amendment, which can be found at Agencywide Documents Access and Management System (ADAMS) Accession Number ML15328A276, the Commission finds that:

A. the exemption is authorized by law;

B. the exemption presents no undue risk to public health and safety;

C. the exemption is consistent with the common defense and security;

D. special circumstances are present in that the application of the rule in this circumstance is not necessary to serve the underlying purpose of the rule;

E. the special circumstances outweigh any decrease in safety that may result from the reduction in standardization caused by the exemption; and

F. the exemption will not result in a significant decrease in the level of safety otherwise provided by the design.

2. Accordingly, the licensee is granted an exemption from the certified AP1000 DCD Tier 2* information, as described in the licensee's request dated May 4, 2015. This exemption is related to, and necessary for, the granting of License Amendment No. 40, which is being issued concurrently with this exemption.

3. As explained in Section 5 of the NRC staff's Safety Evaluation that supports this license amendment (ADAMS Accession Number ML15328A276), this exemption meets the eligibility criteria for categorical exclusion set forth in 10 CFR 51.22(c)(9). Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment needs to be prepared in connection with the issuance of the exemption.

4. This exemption is effective as of the date of its issuance.

III. License Amendment Request

By letter dated May 4, 2015, the licensee requested that the NRC amend the COLs for VCSNS Units 2 and 3, COLs NPF–93 and NPF–94. The proposed amendment is described in Section I, above.

The Commission has determined for these amendments that the application complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

A notice of consideration of issuance of amendment to facility operating license or combined license, as applicable, proposed no significant hazards consideration determination, and opportunity for a hearing in connection with these actions, was published in the **Federal Register** on October 27, 2015 (80 FR 65814). No comments were received during the 60-day comment period.

The Commission has determined that these amendments satisfy the criteria for categorical exclusion in accordance with 10 CFR 51.22. Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment need be prepared for these amendments.

IV. Conclusion

Using the reasons set forth in the combined safety evaluation, the staff granted the exemption and issued the amendment that the licensee requested on May 4, 2015. The exemption and amendment were issued to the licensee on February 1, 2016 as part of a package of documents (ADAMS Accession No. ML15331A026).

Dated at Rockville, Maryland, this 1st day of March 2016.

For the Nuclear Regulatory Commission.

William (Billy) Gleaves,

Senior Project Manager, Licensing Branch 4, Division of New Reactor Licensing, Office of New Reactors.

[FR Doc. 2016–05130 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2016–0025]

Applications and Amendments to Facility Operating Licenses and Combined Licenses Involving Proposed No Significant Hazards Considerations and Containing Sensitive Unclassified Non-Safeguards Information and Order Imposing Procedures for Access to Sensitive Unclassified Non-Safeguards Information

AGENCY: Nuclear Regulatory Commission.

ACTION: License amendment request; opportunity to comment, request a hearing, and petition for leave to intervene; order.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) received and is considering approval of one amendment request. The amendment request is for Turkey Point Nuclear Generating, Unit Nos. 3 and 4. The NRC proposes to determine that the amendment request involves no significant hazards consideration. In addition, the amendment request contains sensitive unclassified non-safeguards information (SUNSI).

DATES: Comments must be filed by April 7, 2016. A request for a hearing must be filed by May 9, 2016. Any potential party as defined in § 2.4 of title 10 of the *Code of Federal Regulations* (10 CFR), who believes access to SUNSI is necessary to respond to this notice must request document access by March 18, 2016.

ADDRESSES: You may submit comments by any of the following methods (unless this document describes a different method for submitting comments on a specific subject):

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2016–0025. Address questions about NRC dockets to Carol Gallagher; telephone: 301–415–3463; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* Cindy Bladey, Office of Administration, Mail Stop: OWFN–12–H08, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

For additional direction on obtaining information and submitting comments, see ''Obtaining Information and Submitting Comments'' in the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Lynn Ronewicz, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington DC 20555–0001; telephone: 301–415–1927, email: *Lynn.Ronewicz@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2016–0025 when contacting the NRC about the availability of information for this action. You may obtain publicly-available information related to this action by any of the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2016–0025.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents*'' and then select ''*Begin Web-based ADAMS Search.*'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced (if it is available in ADAMS) is provided the first time that it is mentioned in the **SUPPLEMENTARY INFORMATION** section.
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

B. Submitting Comments

Please include Docket ID NRC–2016–0025, facility name, unit number(s), application date, and subject in your comment submission.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your comment submission. The NRC posts all comment submissions at *http://www.regulations.gov* as well as enters the comment submissions into ADAMS. The NRC does not routinely edit comment submissions to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the NRC, then you should inform those persons not to include identifying or contact information that they do not want to be publicly disclosed in their comment submission. Your request should state that the NRC does not routinely edit comment submissions to remove such information before making the comment submissions available to the public or entering the comment submissions into ADAMS.

II. Background

Pursuant to Section 189a.(2) of the Atomic Energy Act of 1954, as amended (the Act), the NRC is publishing this notice. The Act requires the Commission to publish notice of any amendments issued, or proposed to be issued and grants the Commission the authority to issue and make immediately effective any amendment to an operating license or combined license, as applicable, upon a determination by the Commission that such amendment involves no significant hazards consideration, notwithstanding the pendency before the Commission of a request for a hearing from any person.

This notice includes a notice of amendments containing SUNSI.

III. Notice of Consideration of Issuance of Amendments to Facility Operating Licenses and Combined Licenses, Proposed No Significant Hazards Consideration Determination, and Opportunity for a Hearing

The Commission has made a proposed determination that the following amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated, or (2) create the possibility of a new or different kind of accident from any accident previously evaluated, or (3) involve a significant reduction in a margin of safety. The basis for this proposed determination for each amendment request is shown below.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of 60 days after the date of publication of this notice. The Commission may issue the license amendment before expiration of the 60-day period provided that its final determination is that the amendment involves no significant hazards consideration. In addition, the Commission may issue the amendment prior to the expiration of the 30-day comment period should circumstances change during the 30-day comment period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility. Should the Commission take action prior to the expiration of either the comment period or the notice period, it will publish a notice of issuance in the **Federal Register**. Should the Commission make a final No Significant Hazards Consideration Determination, any hearing will take place after issuance. The Commission expects that the need to take this action will occur very infrequently.

A. Opportunity To Request a Hearing and Petition for Leave To Intervene

Within 60 days after the date of publication of this notice, any person(s) whose interest may be affected by this action may file a request for a hearing and a petition to intervene with respect to issuance of the amendment to the subject facility operating license or combined license. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's ''Agency Rules of Practice and Procedure'' in 10 CFR part 2. Interested person(s) should consult a current copy of 10 CFR 2.309, which is available at the NRC's PDR, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, Maryland 20852. The NRC's regulations are accessible electronically from the NRC Library on the NRC's Web site at *http://www.nrc.gov/reading-rm/doc-collections/cfr/.* If a request for a hearing or petition for leave to intervene is filed within 60 days, the Commission or a presiding officer designated by the Commission or by the Chief Administrative Judge of the Atomic Safety and Licensing Board Panel will rule on the request and/or petition; and the Secretary or the Chief Administrative Judge of the Atomic Safety and Licensing Board will issue a notice of a hearing or an appropriate order.

As required by 10 CFR 2.309, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following general requirements: (1) The name, address, and telephone number of the requestor or petitioner; (2) the nature of the requestor's/petitioner's

right under the Act to be made a party to the proceeding; (3) the nature and extent of the requestor's/petitioner's property, financial, or other interest in the proceeding; and (4) the possible effect of any decision or order which may be entered in the proceeding on the requestor's/petitioner's interest. The petition must also set forth the specific contentions which the requestor/petitioner seeks to have litigated at the proceeding.

Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the requestor/petitioner shall provide a brief explanation of the basis for the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the requestor/petitioner intends to rely in proving the contention at the hearing. The requestor/petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the requestor/petitioner intends to rely to establish those facts or expert opinion. The petition must include sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the requestor/petitioner to relief. A requestor/petitioner who fails to satisfy these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing with respect to resolution of that person's admitted contentions, including the opportunity to present evidence and to submit a cross-examination plan for cross-examination of witnesses, consistent with NRC regulations, policies and procedures.

Petitions for leave to intervene must be filed no later than 60 days from the date of publication of this notice. Requests for hearing, petitions for leave to intervene, and motions for leave to file new or amended contentions that are filed after the 60-day deadline will not be entertained absent a determination by the presiding officer that the filing demonstrates good cause by satisfying the three factors in 10 CFR 2.309(c)(1)(i)–(iii). If a hearing is requested, and the Commission has not made a final determination on the issue of no significant hazards consideration, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held. If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment. If the final determination is that the amendment request involves a significant hazards consideration, then any hearing held would take place before the issuance of any amendment unless the Commission finds an imminent danger to the health or safety of the public, in which case it will issue an appropriate order or rule under 10 CFR part 2.

A State, local governmental body, Federally-recognized Indian Tribe, or agency thereof, may submit a petition to the Commission to participate as a party under 10 CFR 2.309(h)(1). The petition should state the nature and extent of the petitioner's interest in the proceeding. The petition should be submitted to the Commission by May 9, 2016. The petition must be filed in accordance with the filing instructions in the ''Electronic Submissions (E-Filing)'' section of this document, and should meet the requirements for petitions for leave to intervene set forth in this section, except that under § 2.309(h)(2) a State, local governmental body, or Federally-recognized Indian Tribe, or agency thereof does not need to address the standing requirements in 10 CFR 2.309(d) if the facility is located within its boundaries. A State, local governmental body, Federally-recognized Indian Tribe, or agency thereof may also have the opportunity to participate under 10 CFR 2.315(c).

If a hearing is granted, any person who does not wish, or is not qualified, to become a party to the proceeding may, in the discretion of the presiding officer, be permitted to make a limited appearance pursuant to the provisions of 10 CFR 2.315(a). A person making a limited appearance may make an oral or written statement of position on the issues, but may not otherwise participate in the proceeding. A limited appearance may be made at any session of the hearing or at any prehearing conference, subject to the limits and conditions as may be imposed by the presiding officer. Persons desiring to make a limited appearance are requested to inform the Secretary of the Commission by May 9, 2016.

B. Electronic Submissions (E-Filing)

All documents filed in NRC adjudicatory proceedings, including a request for hearing, a petition for leave to intervene, any motion or other document filed in the proceeding prior to the submission of a request for hearing or petition to intervene, and documents filed by interested governmental entities participating under 10 CFR 2.315(c), must be filed in accordance with the NRC's E-Filing rule (72 FR 49139; August 28, 2007). The E-Filing process requires participants to submit and serve all adjudicatory documents over the Internet, or in some cases to mail copies on electronic storage media. Participants may not submit paper copies of their filings unless they seek an exemption in accordance with the procedures described below.

To comply with the procedural requirements of E-Filing, at least 10 days prior to the filing deadline, the participant should contact the Office of the Secretary by email at *hearing.docket@nrc.gov,* or by telephone at 301–415–1677, to request (1) a digital identification (ID) certificate, which allows the participant (or its counsel or representative) to digitally sign documents and access the E-Submittal server for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a request or petition for hearing (even in instances in which the participant, or its counsel or representative, already holds an NRC-issued digital ID certificate). Based upon this information, the Secretary will establish an electronic docket for the hearing in this proceeding if the Secretary has not already established an electronic docket.

Information about applying for a digital ID certificate is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals/getting-started.html.* System requirements for accessing the E-Submittal server are detailed in the NRC's ''Guidance for Electronic Submission,'' which is available on the agency's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.* Participants may attempt to use other software not listed on the Web site, but should note that the NRC's E-Filing system does not support unlisted software, and the NRC Meta System Help Desk will not be able to offer assistance in using unlisted software.

If a participant is electronically submitting a document to the NRC in accordance with the E-Filing rule, the

participant must file the document using the NRC's online, Web-based submission form. In order to serve documents through the Electronic Information Exchange System, users will be required to install a Web browser plug-in from the NRC's Web site. Further information on the Web-based submission form, including the installation of the Web browser plug-in, is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.*

Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit a request for hearing or petition for leave to intervene. Submissions should be in Portable Document Format (PDF) in accordance with NRC guidance available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.* A filing is considered complete at the time the documents are submitted through the NRC's E-Filing system. To be timely, an electronic filing must be submitted to the E-Filing system no later than 11:59 p.m. Eastern Time on the due date. Upon receipt of a transmission, the E-Filing system time-stamps the document and sends the submitter an email notice confirming receipt of the document. The E-Filing system also distributes an email notice that provides access to the document to the NRC's Office of the General Counsel and any others who have advised the Office of the Secretary that they wish to participate in the proceeding, so that the filer need not serve the documents on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before a hearing request/petition to intervene is filed so that they can obtain access to the document via the E-Filing system.

A person filing electronically using the NRC's adjudicatory E-Filing system may seek assistance by contacting the NRC Meta System Help Desk through the ''Contact Us'' link located on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html*, by email to *MSHD.Resource@nrc.gov*, or by a toll-free call at 1–866–672–7640. The NRC Meta System Help Desk is available between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday, excluding government holidays.

Participants who believe that they have a good cause for not submitting documents electronically must file an exemption request, in accordance with 10 CFR 2.302(g), with their initial paper filing requesting authorization to continue to submit documents in paper format. Such filings must be submitted by: (1) First class mail addressed to the Office of the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemaking and Adjudications Staff; or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, Sixteenth Floor, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852, Attention: Rulemaking and Adjudications Staff. Participants filing a document in this manner are responsible for serving the document on all other participants. Filing is considered complete by first-class mail as of the time of deposit in the mail, or by courier, express mail, or expedited delivery service upon depositing the document with the provider of the service. A presiding officer, having granted an exemption request from using E-Filing, may require a participant or party to use E-Filing if the presiding officer subsequently determines that the reason for granting the exemption from use of E-Filing no longer exists.

Documents submitted in adjudicatory proceedings will appear in the NRC's electronic hearing docket which is available to the public at *http://ehd1.nrc.gov/ehd/*, unless excluded pursuant to an order of the Commission, or the presiding officer. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or home phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. However, in some instances, a request to intervene will require including information on local residence in order to demonstrate a proximity assertion of interest in the proceeding. With respect to copyrighted works, except for limited excerpts that serve the purpose of the adjudicatory filings and would constitute a Fair Use application, participants are requested not to include copyrighted materials in their submission.

For further details with respect to this amendment action, see the application for amendment which is available for public inspection at the NRC's PDR, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, Maryland 20852. Publicly available documents created or received at the NRC are accessible electronically through ADAMS in the NRC Library at *http://www.nrc.gov/reading-rm/adams.html.* If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the PDR's Reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.*

Florida Power & Light Company, Docket Nos. 50–250 and 50–251, Turkey Point Nuclear Generating, Unit Nos. 3 and 4, Miami-Dade County, Florida

Date of amendment request: October 6, 2015. A publicly available version is in ADAMS at Accession No. ML15301A261.

Description of amendment request: This amendment request contains sensitive unclassified non-safeguards information (SUNSI). The amendments would revise the technical specifications (TSs) for Turkey Point Nuclear Generating, Unit Nos. 3 and 4 (Turkey Point), related to moderator temperature coefficient (MTC) requirements.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented as follows:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The safety analysis assumption of a constant moderator density coefficient and the actual value assumed are not changing. The Bases for and values of the most negative MTC Limiting Condition for Operation and for the Surveillance Requirement are not changing. Instead, a revised prediction is compared to the MTC Surveillance limit to determine if the limit is met.

The proposed changes to the TS do not affect the initiators of any analyzed accident. In addition, operation in accordance with the proposed TS changes ensures that the previously evaluated accidents will continue to be mitigated as analyzed. The proposed changes do not adversely affect the design function or operation of any structures, systems, and components important to safety.

The probability or consequences of accidents previously evaluated in the UFSAR [updated final safety analysis report] are unaffected by this proposed change because there is no change to any equipment response or accident mitigation scenario. There are no new or additional challenges to fission product barrier integrity.

Therefore, it is concluded that the proposed changes do not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed changes do not involve a physical alteration of the plant (no new or different type of equipment will be installed).

The proposed changes do not create any new failure modes for existing equipment or any new limiting single failures. Additionally the proposed changes do not involve a change in the methods governing normal plant operation and all safety functions will continue to perform as previously assumed in accident analyses.

Therefore, the proposed changes do not adversely affect the design function or operation of any structures, systems, and components important to safety.

No new accident scenarios, failure mechanisms, or limiting single failures are introduced as a result of the proposed changes. The proposed changes do not challenge the performance or integrity of any safety-related system.

Therefore, it is concluded that the proposed changes do not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The margin of safety associated with the acceptance criteria of any accident is unchanged. The proposed change will have no affect [sic] on the availability, operability, or performance of the safety-related systems and components. A change to a surveillance requirement is proposed based on an alternate method of confirming that the surveillance is met. The Technical Specification Limiting Condition for Operation limits are not being changed.

The proposed change will not adversely affect the operation of plant equipment or the function of equipment assumed in the accident analysis.

Therefore, it is concluded that the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: William S. Blair, Managing Attorney—Nuclear, Florida Power & Light Company, 700 Universe Blvd., MS LAW/JB, Juno Beach, Florida 33408–0420.

NRC Branch Chief: Benjamin G. Beasley.

Order Imposing Procedures for Access to Sensitive Unclassified Non-Safeguards Information for Contention Preparation

Florida Power & Light Company, Docket Nos. 50–250 and 50–251, Turkey Point Nuclear Generating, Unit Nos. 3 and 4, Miami-Dade County, Florida

A. This Order contains instructions regarding how potential parties to this proceeding may request access to documents containing SUNSI.

B. Within 10 days after publication of this notice of hearing and opportunity to petition for leave to intervene, any potential party who believes access to SUNSI is necessary to respond to this notice may request such access. A ''potential party'' is any person who intends to participate as a party by demonstrating standing and filing an admissible contention under 10 CFR 2.309. Requests for access to SUNSI submitted later than 10 days after publication of this notice will not be considered absent a showing of good cause for the late filing, addressing why the request could not have been filed earlier.

C. The requester shall submit a letter requesting permission to access SUNSI to the Office of the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemakings and Adjudications Staff, and provide a copy to the Associate General Counsel for Hearings, Enforcement and Administration, Office of the General Counsel, Washington, DC 20555–0001. The expedited delivery or courier mail address for both offices is: U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852. The email address for the Office of the Secretary and the Office of the General Counsel are *Hearing.Docket@nrc.gov* and *OGCmailcenter@nrc.gov*, respectively.[1] The request must include the following information:

(1) A description of the licensing action with a citation to this **Federal Register** notice;

(2) The name and address of the potential party and a description of the potential party's particularized interest that could be harmed by the action identified in C.(1); and

(3) The identity of the individual or entity requesting access to SUNSI and the requester's basis for the need for the information in order to meaningfully participate in this adjudicatory proceeding. In particular, the request must explain why publicly-available versions of the information requested would not be sufficient to provide the basis and specificity for a proffered contention.

D. Based on an evaluation of the information submitted under paragraph C.(3) the NRC staff will determine within 10 days of receipt of the request whether:

(1) There is a reasonable basis to believe the petitioner is likely to establish standing to participate in this NRC proceeding; and

(2) The requestor has established a legitimate need for access to SUNSI.

E. If the NRC staff determines that the requestor satisfies both D.(1) and D.(2) above, the NRC staff will notify the requestor in writing that access to SUNSI has been granted. The written notification will contain instructions on how the requestor may obtain copies of the requested documents, and any other conditions that may apply to access those documents. These conditions may include, but are not limited to, the signing of a Non-Disclosure Agreement or Affidavit, or Protective Order[2] setting forth terms and conditions to prevent the unauthorized or inadvertent disclosure of SUNSI by each individual who will be granted access to SUNSI.

F. Filing of Contentions. Any contentions in these proceedings that are based upon the information received as a result of the request made for SUNSI must be filed by the requestor no later than 25 days after the requestor is granted access to that information. However, if more than 25 days remain between the date the petitioner is granted access to the information and the deadline for filing all other contentions (as established in the notice of hearing or opportunity for hearing), the petitioner may file its SUNSI contentions by that later deadline. This provision does not extend the time for filing a request for a hearing and petition to intervene, which must comply with the requirements of 10 CFR 2.309.

G. Review of Denials of Access.

(1) If the request for access to SUNSI is denied by the NRC staff after a determination on standing and need for access, the NRC staff shall immediately notify the requestor in writing, briefly stating the reason or reasons for the denial.

(2) The requester may challenge the NRC staff's adverse determination by filing a challenge within 5 days of receipt of that determination with: (a) The presiding officer designated in this proceeding; (b) if no presiding officer has been appointed, the Chief Administrative Judge, or if he or she is unavailable, another administrative judge, or an administrative law judge with jurisdiction pursuant to 10 CFR 2.318(a); or (c) officer if that officer has been designated to rule on information access issues.

[1] While a request for hearing or petition to intervene in this proceeding must comply with the filing requirements of the NRC's ''E-Filing Rule,'' the initial request to access SUNSI under these procedures should be submitted as described in this paragraph.

[2] Any motion for Protective Order or draft Non-Disclosure Affidavit or Agreement for SUNSI must be filed with the presiding officer or the Chief Administrative Judge if the presiding officer has not yet been designated, within 30 days of the deadline for the receipt of the written access request.

H. Review of Grants of Access. A party other than the requester may challenge an NRC staff determination granting access to SUNSI whose release would harm that party's interest independent of the proceeding. Such a challenge must be filed with the Chief Administrative Judge within 5 days of the notification by the NRC staff of its grant of access.

If challenges to the NRC staff determinations are filed, these procedures give way to the normal process for litigating disputes concerning access to information. The availability of interlocutory review by the Commission of orders ruling on such NRC staff determinations (whether granting or denying access) is governed by 10 CFR 2.311.[3]

I. The Commission expects that the NRC staff and presiding officers (and any other reviewing officers) will consider and resolve requests for access to SUNSI, and motions for protective orders, in a timely fashion in order to minimize any unnecessary delays in identifying those petitioners who have standing and who have propounded contentions meeting the specificity and basis requirements in 10 CFR part 2. Attachment 1 to this Order summarizes the general target schedule for processing and resolving requests under these procedures.

It is so ordered.

Dated at Rockville, Maryland, 16th day of February 2016.

For the Nuclear Regulatory Commission.

Rochelle C. Bavol,

Acting Secretary of the Commission.

ATTACHMENT 1—GENERAL TARGET SCHEDULE FOR PROCESSING AND RESOLVING REQUESTS FOR ACCESS TO SENSITIVE UNCLASSIFIED NON-SAFEGUARDS INFORMATION IN THIS PROCEEDING

Day	Event/activity
0	Publication of **Federal Register** notice of hearing and opportunity to petition for leave to intervene, including order with instructions for access requests.
10	Deadline for submitting requests for access to Sensitive Unclassified Non-Safeguards Information (SUNSI) with information: Supporting the standing of a potential party identified by name and address; describing the need for the information in order for the potential party to participate meaningfully in an adjudicatory proceeding.
60	Deadline for submitting petition for intervention containing: (i) Demonstration of standing; and (ii) all contentions whose formulation does not require access to SUNSI (+25 Answers to petition for intervention; +7 petitioner/requestor reply).
20	U.S. Nuclear Regulatory Commission (NRC) staff informs the requester of the staff's determination whether the request for access provides a reasonable basis to believe standing can be established and shows need for SUNSI. (NRC staff also informs any party to the proceeding whose interest independent of the proceeding would be harmed by the release of the information.) If NRC staff makes the finding of need for SUNSI and likelihood of standing, NRC staff begins document processing (preparation of redactions or review of redacted documents).
25	If NRC staff finds no "need" or no likelihood of standing, the deadline for petitioner/requester to file a motion seeking a ruling to reverse the NRC staff's denial of access; NRC staff files copy of access determination with the presiding officer (or Chief Administrative Judge or other designated officer, as appropriate). If NRC staff finds "need" for SUNSI, the deadline for any party to the proceeding whose interest independent of the proceeding would be harmed by the release of the information to file a motion seeking a ruling to reverse the NRC staff's grant of access.
30	Deadline for NRC staff reply to motions to reverse NRC staff determination(s).
40	(Receipt +30) If NRC staff finds standing and need for SUNSI, deadline for NRC staff to complete information processing and file motion for Protective Order and draft Non-Disclosure Affidavit. Deadline for applicant/licensee to file Non-Disclosure Agreement for SUNSI.
A	If access granted: Issuance of presiding officer or other designated officer decision on motion for protective order for access to sensitive information (including schedule for providing access and submission of contentions) or decision reversing a final adverse determination by the NRC staff.
A + 3	Deadline for filing executed Non-Disclosure Affidavits. Access provided to SUNSI consistent with decision issuing the protective order.
A + 28	Deadline for submission of contentions whose development depends upon access to SUNSI. However, if more than 25 days remain between the petitioner's receipt of (or access to) the information and the deadline for filing all other contentions (as established in the notice of hearing or opportunity for hearing), the petitioner may file its SUNSI contentions by that later deadline.
A + 53	(Contention receipt +25) Answers to contentions whose development depends upon access to SUNSI.
A + 60	(Answer receipt +7) Petitioner/Intervenor reply to answers.
>A + 60	Decision on contention admission.

[FR Doc. 2016–03589 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 40–9091; NRC–2011–0148]

Strata Energy, Inc, Kendrick Expansion Area In Situ Uranium Recovery Project

AGENCY: Nuclear Regulatory Commission.

ACTION: Intent to prepare a supplemental environmental impact statement and conduct a scoping process; request for comment.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) received a license amendment application for License SUA–1601, by letters dated March 20, 2015, and April 24, 2015, from Strata Energy, Inc. (Strata). The amendment application requested authorization to expand its Ross *In Situ* Uranium Recovery (ISR) Project (Ross) to include the Kendrick expansion area (Kendrick). The requested amendment would allow Strata to construct and operate additional uranium recovery wells at Kendrick. Kendrick covers approximately 3,186 hectares (7,784 acres) adjacent to Ross. Ross is located in Crook County, Wyoming, 43 kilometers (27 miles) northeast of Gillette, Wyoming and 46 kilometers (29 miles) northwest of Sundance, Wyoming. A notice of license

[3] Requesters should note that the filing requirements of the NRC's E-Filing Rule (72 FR 49139; August 28, 2007) apply to appeals of NRC staff determinations (because they must be served on a presiding officer or the Commission, as applicable), but not to the initial SUNSI request submitted to the NRC staff under these procedures.

amendment request and opportunity to request a hearing was published in the *Federal Register* on February 29, 2016.

DATES: The scoping period begins March 8, 2016 and ends April 22, 2016.

ADDRESSES: Please refer to Docket ID NRC–2011–0148 when providing scoping comments or contacting the NRC about the availability of information regarding this document. You may submit scoping comments by the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2011–0148. Address questions about NRC dockets to Carol Gallagher; telephone: 301–415–3463; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* Cindy Bladey, Office of Administration, Mail Stop: OWFN–12–H08, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.
- *Email Comments to:* You may email scoping comments to the Project's email address: *KendrickSEIS@nrc.gov.*

Comments must be submitted by April 22, 2016 to ensure consideration. For additional direction on accessing information and submitting comments, see ''Obtaining Information and Submitting Comments'' in the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Jessie Muir Quintero, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–7476; email: *Jessie.Muir-Quintero@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2011–0148 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this action by the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2011–0148.
- *NRC's Agencywide Documents Access and Management System (ADAMS):*

You may obtain publicly-available documents online in the ADAMS Public Documents collection at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents''* and then select ''*Begin Web-based ADAMS Search.''* For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* For the convenience of the reader, instructions about obtaining materials referenced in this document are provided in a table in the section of this notice entitle, Availability of Documents.

- *NRC'S PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.
- *Project Web page:* Information related to the Kendrick project can be accessed on the NRC's Kendrick Project Web page at: *http://www.nrc.gov/materials/uranium-recovery/license-apps/kendrick.html.*

B. Submitting Comments

Please include Docket ID NRC–2011–0148 in your comment submission. Written comments may be submitted during the 45-day scoping period as described in the **ADDRESSES** section of the document.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your comment submission. The NRC posts all comment submissions at *http://www.regulations.gov* as well as entering the comment submissions into ADAMS. The NRC does not routinely edit comment submissions to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the NRC, then you should inform those persons not to include identifying or contact information that they do not want to be publicly disclosed in their comment submission. Your request should state that the NRC does not routinely edit comment submissions to remove such information before making the comment submissions available to the public or entering the comment submissions into ADAMS.

II. Background

On April 24, 2014, the NRC staff issued Strata a source and byproduct material license, SUA–1601, pursuant to part 40 of title 10 of the *Code of Federal Regulations* (10 CFR). License SUA–1601 authorizes Strata to construct and operate its Ross ISR project, which includes ISR wellfields, a central processing plant (CPP), and ancillary facilities within the 696-hectare (1,721-acre) Ross site located in Crook County, Wyoming. Prior to granting Strata SUA–1601, the NRC staff conducted an environmental review of the proposed project and issued a Supplemental Environmental Impact Statement (SEIS) for the Ross ISR Project (Ross SEIS, NUREG–1910, Supplement 5), in February 2014. The Ross SEIS tiered off the ISR Generic Environmental Impact Statement (GEIS, NUREG–1910).

By letters dated March 20, 2015, and April 24, 2015, Strata requested that the NRC amend License SUA–1601. The requested amendment, if granted, would expand the area of ISR activities to include the Kendrick expansion area, which is adjacent to Ross, and allow Strata to construct and operate additional uranium ISR wellfields at Kendrick.

The NRC accepted the license amendment application for technical review on January 14, 2016, and published a notice of opportunity to request a hearing in the **Federal Register** on February 29, 2016 (81 FR 10285). Strata's license amendment application, including an Environmental Report, can be found on the NRC's Kendrick project Web page at: *http://www.nrc.gov/materials/uranium-recovery/license-apps/kendrick.html.*

The purpose of this notice is to: (1) Inform the public that the NRC staff will prepare a SEIS to the GEIS as part of its review of the license amendment request, and (2) provide the public with an opportunity to participate in the environmental scoping process as defined in 10 CFR 51.29.

III. Environmental Review

Although the NRC typically prepares Environmental Assessments for source material license amendments, the NRC staff is preparing a SEIS for Kendrick because the Ross SEIS identified several potential significant impacts related to historic and cultural resources, groundwater, transportation, and visual resources. Therefore, the NRC has considered it prudent to prepare a SEIS for this particular license amendment. The SEIS for Kendrick will be prepared pursuant to the NRC's regulations that implement NEPA. These regulations are located in ''10 CFR part 51.''

The Kendrick SEIS will examine the potential environmental impacts of the proposed construction, operation, decommissioning, and aquifer restoration of the Kendrick expansion area. The Kendrick SEIS will tier from and incorporate by reference the GEIS and the Ross SEIS. The techniques of tiering and incorporation by reference are described in 40 CFR 1502.20 and 1508.28, and 40 CFR 1502.21, respectively, of the Council on

Environmental Quality's NEPA regulations. Accordingly, the SEIS will rely on information and analyses in the GEIS and Ross SEIS where appropriate and focus its more detailed discussions on the issues specific to Kendrick.

The SEIS will analyze potential impacts of the proposed action on historic and cultural resources. In accordance with 36 CFR 800.8, the NRC staff is using the NEPA process to comply with its obligations under Section 106 of the National Historic Preservation Act. The NRC initiated Section 106 consultations beginning in July 2015, with 26 Indian Tribes, the U.S. National Park Service—Devils Tower, the U.S. Bureau of Land Management (BLM), the Advisory Council on Historic Preservation, and the Wyoming State Historic Preservation Office.

In parallel with the environmental review, the NRC will be conducting a safety review. Its findings will be published in a Safety Evaluation Report.

IV. Kendrick Expansion Area

The NRC's Federal action is to either grant or deny Strata's request for a license amendment. If the NRC approves Strata's request to amend License SUA–1601, then Strata could proceed with the proposed project—the Kendrick expansion—as described in its license amendment application. With this expansion, Strata would extract uranium from the ore body at Kendrick through the ISR process.

The ISR process involves the mobilization of uranium from the mineralized host sandstone rock by pumping native groundwater containing oxidants (oxygen or hydrogen peroxide) and other chemical compounds (*e.g.,* sodium bicarbonate) through a series of injection wells, passing the fluids through the ore body and then being extracted to the surface through a series of production wells. After extraction, the solution, called ''lixiviant,'' would be transported by pipelines to the Ross CPP for processing. Strata does not propose to construct or operate processing plants at Kendrick. After removal of the uranium by an ion-exchange process at the Ross CPP, the resulting solution would be transported back to Kendrick by pipeline for re-use in ISR operations. Uranium removed at the Ross CPP would be further processed to produce ''yellowcake,'' either at the Ross CPP should the dryers be installed in the future or through the transfer of uranium-bearing resins for processing at another licensed facility. The yellowcake would then be shipped to a uranium conversion facility which is the next step in the fuel cycle process for developing fuel for commercial nuclear power plants. Kendrick wellfields that have completed operations would be decommissioned and the affected aquifers restored concurrently with operation of other active wellfields.

V. Alternatives To Be Evaluated

The Kendrick SEIS will analyze the environmental impacts of the proposed action, the no-action alternative, and reasonable alternatives. A brief description of each is provided below.

No-Action—The no-action alternative would be to deny the license amendment application. Under this alternative, the NRC would not issue the license amendment and no ISR activities would occur at Kendrick. This serves as a baseline for comparison.

Proposed action—The proposed Federal action is to issue a license amendment authorizing the expansion of Ross ISR activities to Kendrick. If the NRC approves the amendment request, it would issue Strata an amended license (SUA–1601) under the provisions of 10 CFR part 40, and Strata would proceed with the proposed activities at Kendrick as described in its license amendment application and summarized in Section IV.

Alternatives—In its Environmental Report, Strata identified a potential alternative involving the construction of a satellite ion-exchange facility within Kendrick. Under this alternative, lixiviant from the proposed Kendrick wellfields would be pumped to a satellite facility within Kendrick rather than to the Ross CPP. At the Kendrick satellite facility, uranium would be extracted in ion-exchange columns and transported to either the Ross CPP or another licensed facility for processing into yellowcake. Other alternatives not listed here may be identified during scoping or through the environmental review process.

VI. Scope of the Environmental Review

The NRC will first conduct a scoping process for the SEIS and as soon as practicable thereafter, will publish a draft SEIS, pursuant to the NRC's NEPA regulations at 10 CFR part 51, for public comment. The NRC staff is conducting a 45-day scoping process for the Kendrick SEIS. The purpose of this scoping process is to seek public input to help the NRC determine the appropriate scope of the SEIS, including the alternatives and significant environmental issues to be analyzed in depth, as well as those that should be eliminated from detailed study because they are peripheral or are not significant. The NRC staff is planning to publish information related to this action in newspapers serving communities near the Kendrick site, requesting information and comments during the scoping period from the public. At this time, the NRC is not planning to hold a public scoping meeting. The NRC will prepare a concise summary of its scoping process, the comments received, as well as the NRC's responses. The Scoping Summary Report will be included in the draft SEIS as an appendix and sent to each participant in the scoping process for whom the staff has an address.

The Kendrick SEIS will cover the potential impacts from all project phases: construction, operations, aquifer restoration, and decommissioning. The scope of the Kendrick SEIS will consider both radiological and nonradiological (including chemical) impacts associated with the proposed project and its alternatives. The Kendrick SEIS will also consider unavoidable adverse environmental impacts, the relationship between short-term uses of resources and long-term productivity, and irreversible and irretrievable commitments of resources. The following resource areas have been tentatively identified for analysis in the Kendrick SEIS: land use, transportation, geology and soils, water resources, ecological resources, air quality and climate change, noise, historical and cultural resources, visual and scenic resources, socioeconomics, public and occupational health, waste management, environmental justice, and cumulative impacts. This list is not intended to be exhaustive, nor is it a predetermination of potential environmental impacts. The Kendrick SEIS will describe the NRC's approach and methodology undertaken to determine the resource areas that will be studied in detail.

The NRC encourages members of the public, local, State, Tribal, and Federal government agencies to participate in the scoping process. Written comments may be submitted during the 45-day scoping period as described in the **ADDRESSES** and **SUPPLEMENTARY INFORMATION** section of this document. To ensure that comments will be considered in the scoping process, written comments must be postmarked or delivered by April 22, 2016. The NRC staff may, at its discretion, consider comments after the end of the comment period. Participation in the scoping process for the Kendrick SEIS does not entitle participants to become parties to any proceeding to which the SEIS relates.

In addition to requesting scoping comments through this **Federal Register** notice, the NRC staff also intends to

reach out to interested parties, including those identified during the environmental review for the Ross SEIS, as well as other Federal and State agencies and Indian Tribes identified during the Kendrick SEIS process. The NRC staff seeks to identify, among other things, all review and consultation requirements related to the proposed action, and agencies with jurisdiction by law or special expertise with respect to any environmental impact involved or which is authorized to develop and enforce relevant environmental standards. The NRC invites such agencies to participate in the scoping process and, as appropriate, cooperate in the preparation of the SEIS.

The BLM has accepted the NRC's request to participate as a cooperating agency in the preparation of the SEIS. The BLM has expertise in mineral management and was a cooperating agency for the Ross SEIS. The agencies will cooperate according to the process set forth in the memorandum of understanding signed by the NRC and BLM and published in the **Federal Register** on April 01, 2013 (78 FR 19540).

The NRC will continue its environmental review of Strata's license amendment application and, as soon as practicable, the NRC and its contractor will prepare and publish a draft SEIS. The NRC currently plans to have a 45-day public comment period for the draft SEIS. Availability of the draft SEIS and the dates of the public comment period will be announced in a future **Federal Register** notice. The final SEIS will include responses to public comments received on the draft SEIS.

VII. Availability of Documents

The documents identified in this **Federal Register** notice are accessible to interested persons by the means indicated in either the **SUPPLEMENTARY INFORMATION** section of this notice or in the table below.

Document	Access
NUREG–1910, Generic Environmental Impact Statement for In-Situ Leach Uranium Milling Facilities (GEIS).	*http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1910/.*
NUREG–1910, Supplement 5, Environmental Impact Statement for the Ross ISR Project in Crook County, Wyoming (Ross SEIS).	ML14056A096 or *http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1910/s5/.*
Memorandum of Understanding between NRC and BLM	78 FR 19540.
Federal Register Notice of License Amendment Request and Opportunity to Request a Hearing.	(81 FR 10285).
Strata Energy, LLC's Source Materials License SUA–1601 and Amendments.	ML14069A315, ML15181A246, and ML15202A143 or *http://www.nrc.gov/info-finder/materials/uranium/licensed-facilities/ross.html.*
Kendrick License Amendment Application	ML15096A141 and ML15152A154 or *http://www.nrc.gov/materials/uranium-recovery/license-apps/kendrick/kendrick-app-docs.html.*

Dated at Rockville, Maryland, this 1st day of March, 2016.

For the Nuclear Regulatory Commission.

Craig G. Erlanger,

Acting Director, Division of Fuel Cycle Safety, Safeguards and Environmental Review, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2016–05127 Filed 3–7–16; 8:45 am]

BILLING CODE 7590–01–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for Review: Reinstatement of Disability Annuity Previously Terminated Because of Restoration to Earning Capacity, RI 30–9, 3206–0138

AGENCY: U.S. Office of Personnel Management.

ACTION: 60-Day Notice and request for comments.

SUMMARY: The Retirement Services, Office of Personnel Management (OPM) offers the general public and other Federal agencies the opportunity to comment on the reinstatement of an expired collection without change (ICR) 3206–0138, Reinstatement of Disability Annuity Previously Terminated Because of Restoration to Earning Capacity. As required by the Paperwork Reduction Act of 1995 (Public Law 104–13, 44 U.S.C. chapter 35) as amended by the Clinger-Cohen Act (Pub. L. 104–106), OPM is soliciting comments for this collection.

DATES: Comments are encouraged and will be accepted until May 9, 2016. This process is conducted in accordance with 5 CFR 1320.1.

ADDRESSES: Interested persons are invited to submit written comments on the proposed information collection to Retirement Services, U.S. Office of Personnel Management, 1900 E Street NW., Washington, DC 20415, Attention: Alberta Butler, Room 2347–E, or sent via email to *Alberta.Butler@opm.gov.*

FOR FURTHER INFORMATION CONTACT: A copy of this ICR with applicable supporting documentation, may be obtained by contacting the Retirement Services Publications Team, Office of Personnel Management, 1900 E Street NW., Room 3316–L, Washington, DC 20415, Attention: Cyrus S. Benson, or sent via email to *Cyrus.Benson@opm.gov* or faxed to (202) 606–0910.

SUPPLEMENTARY INFORMATION: The Office of Management and Budget is particularly interested in comments that:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

RI 30–9, Reinstatement of Disability Annuity Previously Terminated Because of Restoration to Earning Capacity informs disability annuitants of their right to request restoration under title 5, U.S.C Sections 8337 and 8455. It also specifies the conditions to be met and the documentation required for a person to request reinstatement.

Analysis

Agency: Retirement Operations, Retirement Services, Office of Personnel Management.

Title: Reinstatement of Disability Annuity Previously Terminated Because of Restoration to Earning Capacity.

OMB: 3206–0138.

Frequency: On occasion.

Affected Public: Individuals or Households.

Number of Respondents: 200.

Estimated Time per Respondent: 60 minutes.

Total Burden Hours: 200.

U.S. Office of Personnel Management.

Beth F. Cobert,

Acting Director.

[FR Doc. 2016–05116 Filed 3–7–16; 8:45 am]

BILLING CODE 6325–38–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for Review: Annuitant's Report of Earned Income, RI 30–2, 3206–0034

AGENCY: U.S. Office of Personnel Management.

ACTION: 60-day notice and request for comments.

SUMMARY: The Retirement Services, Office of Personnel Management (OPM) offers the general public and other Federal agencies the opportunity to comment on the reinstatement of an expired information collection with change (ICR) 3206–0034, Annuitant's Report of Earned Income. As required by the Paperwork Reduction Act of 1995 (Public Law 104–13, 44 U.S.C. chapter 35) as amended by the Clinger-Cohen Act (Pub. L. 104–106), OPM is soliciting comments for this collection.

DATES: Comments are encouraged and will be accepted until May 9, 2016. This process is conducted in accordance with 5 CFR 1320.1.

ADDRESSES: Interested persons are invited to submit written comments on the proposed information collection to Retirement Services, U.S. Office of Personnel Management, 1900 E Street NW., Washington, DC 20415, Attention: Alberta Butler, Room 2347E, or sent via email to *Alberta.Butler@opm.gov.*

FOR FURTHER INFORMATION CONTACT: A copy of this ICR with applicable supporting documentation, may be obtained by contacting the Retirement Services Publications Team, Office of Personnel Management, 1900 E Street NW., Room 3316–L, Washington, DC 20415, Attention: Cyrus S. Benson, or sent via email to *Cyrus.Benson@opm.gov* or faxed to (202) 606–0910.

SUPPLEMENTARY INFORMATION: The Office of Management and Budget is particularly interested in comments that:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

RI 30–2, Annuitant's Report of Earned Income is used annually to determine if disability retirees under age 60 have earned income which will result in the termination of their annuity benefits under title 5, U.S.C. Sections 8337 and 8455. It also specifies the conditions to be met and the documentation required for a person to request reinstatement.

Analysis

Agency: Retirement Operations, Retirement Services, Office of Personnel Management.

Title: Annuitant's Report of Earned Income.

OMB Number: 3206–0034.

Frequency: On occasion.

Affected Public: Individuals or Households.

Number of Respondents: 21,000.

Estimated Time Per Respondent: 35 minutes.

Total Burden Hours: 12,250.

U.S. Office of Personnel Management.

Beth F. Cobert,

Acting Director.

[FR Doc. 2016–05115 Filed 3–7–16; 8:45 am]

BILLING CODE 6325–38–P

OFFICE OF PERSONNEL MANAGEMENT

Submission for Review: Initial Certification of Full-Time School Attendance, RI 25–41, 3206–0099

AGENCY: U.S. Office of Personnel Management.

ACTION: 60-Day notice and request for comments.

SUMMARY: The Retirement Services, Office of Personnel Management (OPM) offers the general public and other Federal agencies the opportunity to comment on the reinstatement of an expired information collection without change (ICR) 3206–0099, Initial Certification of Full-Time School Attendance. As required by the Paperwork Reduction Act of 1995 (Public Law 104–13, 44 U.S.C. chapter 35) as amended by the Clinger-Cohen Act (Pub. L. 104–106), OPM is soliciting comments for this collection.

DATES: Comments are encouraged and will be accepted until May 9, 2016. This process is conducted in accordance with 5 CFR 1320.1.

ADDRESSES: Interested persons are invited to submit written comments on the proposed information collection to Retirement Services, U.S. Office of Personnel Management, 1900 E Street NW., Washington, DC 20415, Attention: Alberta Butler, Room 2349, or sent via email to *Alberta.Butler@opm.gov.*

FOR FURTHER INFORMATION CONTACT: A copy of this ICR with applicable supporting documentation, may be obtained by contacting the Retirement Services Publications Team, Office of Personnel Management, 1900 E Street NW., Room 3316–AC, Washington, DC 20415, Attention: Cyrus S. Benson, or sent via email to *Cyrus.Benson@opm.gov* or faxed to (202) 606–0910.

SUPPLEMENTARY INFORMATION: The Office of Management and Budget is particularly interested in comments that:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

RI 25–41, Initial Certification of Full-Time School Attendance is used to determine whether a child is unmarried and a full-time student in a recognized school. OPM must determine this in order to pay survivor annuity benefits to children who are age 18 or older under

title 5, U.S.C Sections 8341(A)(4) and Chapter 84, Section 8441 (4)(C).

Analysis

Agency: Retirement Operations, Retirement Services, Office of Personnel Management.

Title: Initial Certification of Full-Time School Attendance.

OMB: 3206–0099.

Frequency: On occasion.

Affected Public: Individuals or Households.

Number of Respondents: 1, 200.

Estimated Time per Respondent: 90 minutes.

Total Burden Hours: 1800.

U.S. Office of Personnel Management.

Beth F. Cobert,

Acting Director.

[FR Doc. 2016–05117 Filed 3–7–16; 8:45 am]

BILLING CODE 6325–38–P

POSTAL REGULATORY COMMISSION

[Docket No. CP2014–32; Order No. 3125]

New Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing concerning an amendment to Priority Mail Contract 78 negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* March 9, 2016.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Introduction
II. Notice of Filings
III. Ordering Paragraphs

I. Introduction

On March 1, 2016, the Postal Service filed notice that it has agreed to an amendment to the existing Priority Mail Contract 78 negotiated service agreement approved in this docket.[1] In support of its Notice, the Postal Service includes a redacted copy of the Amendment and a certification of compliance with 39 U.S.C. 3633(a), as required by 39 CFR 3015.5.

The Postal Service also filed the unredacted Amendment and supporting financial information under seal. The Postal Service seeks to incorporate by reference the Application for Non-Public Treatment originally filed in this docket for the protection of information that it has filed under seal. Notice at 1.

The Amendment replaces sections I.F. and I.H. in the contract to amend the prices and annual adjustment terms. *Id.* Attachment A at 1–4.

The Postal Service intends for the Amendment to become effective the later of March 12, 2016, or two business days after the date that the Commission completes its review of the Notice. Notice at 1. The Postal Service asserts that the Amendment will not impair the ability of the contract to comply with 39 U.S.C. 3633. *Id.* Attachment B.

II. Notice of Filings

The Commission invites comments on whether the changes presented in the Postal Service's Notice are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642, 39 CFR 3015.5, and 39 CFR part 3020, subpart B. Comments are due no later than March 9, 2016. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Curtis E. Kidd to represent the interests of the general public (Public Representative) in this docket.

III. Ordering Paragraphs

It is ordered:

1. The Commission reopens Docket No. CP2014–32 for consideration of matters raised by the Postal Service's Notice.

2. Pursuant to 39 U.S.C. 505, the Commission appoints Curtis E. Kidd to serve as an officer of the Commission (Public Representative) to represent the interests of the general public in this proceeding.

3. Comments are due no later than March 9, 2016.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

By the Commission.

Stacy L. Ruble,

Secretary.

[FR Doc. 2016–05030 Filed 3–7–16; 8:45 am]

BILLING CODE 7710–FW–P

[1] Notice of United States Postal Service of Change in Prices Pursuant to Amendment to Priority Mail Contract 78, March 1, 2016 (Notice). The amendment is an attachment to the Notice (Amendment).

POSTAL REGULATORY COMMISSION

[Docket No. CP2015–32; Order No. 3124]

New Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing concerning an amendment to Priority Mail & First-Class Package Service Contract 2 negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* March 9, 2016.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Introduction
II. Notice of Filings
III. Ordering Paragraphs

I. Introduction

On March 1, 2016, the Postal Service filed notice that it has agreed to an amendment to the existing Priority Mail & First-Class Package Service Contract 2 negotiated service agreement approved in this docket.[1] In support of its Notice, the Postal Service includes a redacted copy of the Amendment and a certification of compliance with 39 U.S.C. 3633(a), as required by 39 CFR 3015.5.

The Postal Service also filed the unredacted Amendment and supporting financial information under seal. The Postal Service seeks to incorporate by reference the Application for Non-Public Treatment originally filed in this docket for the protection of information that it has filed under seal. Notice at 1.

The Amendment replaces Sections I.F. and I.G. regarding contract prices and price adjustments. *Id.* Attachment A at 1–2.

The Postal Service intends for the Amendment to become effective two

[1] Notice of United States Postal Service of Change in Prices Pursuant to Amendment to Priority Mail & First-Class Package Service Contract 2, March 1, 2016 (Notice). The amendment is an attachment to the Notice (Amendment).

business days after the date that the Commission completes its review of the Notice. Notice at 1; *id.* Attachment A at 1. The Postal Service asserts that the Amendment will not impair the ability of the contract to comply with 39 U.S.C. 3633. Notice, Attachment B at 1.

II. Notice of Filings

The Commission invites comments on whether the changes presented in the Postal Service's Notice are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642, 39 CFR 3015.5, and 39 CFR part 3020, subpart B. Comments are due no later than March 9, 2016. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Curtis E. Kidd to represent the interests of the general public (Public Representative) in this docket.

III. Ordering Paragraphs

It is ordered:

1. The Commission reopens Docket No. CP2015–32 for consideration of matters raised by the Postal Service's Notice.

2. Pursuant to 39 U.S.C. 505, the Commission appoints Curtis E. Kidd to serve as an officer of the Commission (Public Representative) to represent the interests of the general public in this proceeding.

3. Comments are due no later than March 9, 2016.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

By the Commission.

Stacy L. Ruble,

Secretary.

[FR Doc. 2016–05029 Filed 3–7–16; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2016–89 and CP2016–114; Order No. 3126]

New Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing concerning the addition of Priority Mail and First-Class Package Service Contract 15 negotiated service agreement to the competitive product list. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* March 9, 2016.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Introduction
II. Notice of Commission Action
III. Ordering Paragraphs

I. Introduction

In accordance with 39 U.S.C. 3642 and 39 CFR 3020.30–.35, the Postal Service filed a formal request and associated supporting information to add Priority Mail & First-Class Package Service Contract 15 to the competitive product list.[1]

The Postal Service contemporaneously filed a redacted contract related to the proposed new product under 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. Notice, Attachment B.

To support its Request, the Postal Service filed a copy of the contract, a copy of the Governors' Decision authorizing the product, proposed changes to the Mail Classification Schedule, a Statement of Supporting Justification, a certification of compliance with 39 U.S.C. 3633(a), and an application for non-public treatment of certain materials. It also filed supporting financial workpapers.

II. Notice of Commission Action

The Commission establishes Docket Nos. MC2016–89 and CP2016–114 to consider the Request pertaining to the proposed Priority Mail & First-Class Package Service Contract 15 product and the related contract, respectively.

The Commission invites comments on whether the Postal Service's filings in the captioned dockets are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642, 39 CFR part 3015, and 39 CFR part 3020, subpart B. Comments are due no later than March 9, 2016. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

[1] Request of the United States Postal Service to Add Priority Mail & First-Class Package Service Contract 15 to Competitive Product List and Notice of Filing (Under Seal) of Unredacted Governors' Decision, Contract, and Supporting Data, March 1, 2016 (Request).

The Commission appoints Jennaca D. Upperman to serve as Public Representative in these dockets.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket Nos. MC2016–89 and CP2016–114 to consider the matters raised in each docket.

2. Pursuant to 39 U.S.C. 505, Jennaca D. Upperman is appointed to serve as an officer of the Commission to represent the interests of the general public in these proceedings (Public Representative).

3. Comments are due no later than March 9, 2016.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

By the Commission.

Stacy L. Ruble,

Secretary.

[FR Doc. 2016–05031 Filed 3–7–16; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL SERVICE

Product Change—Priority Mail and First-Class Package Service Negotiated Service Agreement

AGENCY: Postal Service™.

ACTION: Notice.

SUMMARY: The Postal Service gives notice of filing a request with the Postal Regulatory Commission to add a domestic shipping services contract to the list of Negotiated Service Agreements in the Mail Classification Schedule's Competitive Products List.

DATES: *Effective date:* March 8, 2016.

FOR FURTHER INFORMATION CONTACT: Elizabeth A. Reed, 202–268–3179.

SUPPLEMENTARY INFORMATION: The United States Postal Service® hereby gives notice that, pursuant to 39 U.S.C. 3642 and 3632(b)(3), on March 1, 2016, it filed with the Postal Regulatory Commission a *Request of the United States Postal Service to Add Priority Mail & First-Class Package Service Contract 15 to Competitive Product List.* Documents are available at *www.prc.gov,* Docket Nos. MC2016–89, CP2016–114.

Stanley F. Mires,

Attorney, Federal Compliance.

[FR Doc. 2016–05053 Filed 3–7–16; 8:45 am]

BILLING CODE 7710–12–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77279; File No. SR–NYSEMKT–2016–32]

Self-Regulatory Organizations; NYSE MKT LLC; Notice of Filing and Immediate Effectiveness of a Proposed Change Amending the Fees for NYSE MKT Proprietary Market Data as They Apply to Federal Agency Customers

March 3, 2016.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on February 26, 2016, NYSE MKT LLC (the ''Exchange'' or ''NYSE MKT'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the fees for NYSE MKT proprietary market data as they apply to Federal agency customers. The proposed change is available on the Exchange's Web site at *www.nyse.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the NYSE MKT Equities Proprietary Market Data Fee Schedule (''Fee Schedule''), to provide that market data fees do not apply to any Federal agency for their use of NYSE MKT real-time proprietary market data products. The term ''Federal agency'' as used in the Fee Schedule would include all Federal agencies subject to the Federal Acquisition Regulation (FAR),[4] as well as any Federal agency not subject to FAR that has promulgated its own procurement rules.[5]

The Exchange is proposing to specify that access fees, professional user fees and non-display fees do not apply to Federal agencies for those products to which those fees apply.[6] The proposal is designed to allow the Exchange to provide Federal agencies with NYSE MKT real-time proprietary market data products at no cost in support of Federal agencies' regulatory responsibilities. With the adoption of the proposed fee waiver, the Exchange is not waiving any of its contractual rights and all Federal agencies that subscribe to NYSE MKT real-time proprietary market data products will be required to execute the appropriate subscriber agreement, which include [sic], among other things, provisions against the redistribution of data.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[7] in general, and Sections 6(b)(4) and 6(b)(5) of the Act,[8] in particular, in that it provides an equitable allocation of reasonable fees among users and recipients of the data and is not designed to permit unfair discrimination among customers, issuers, and brokers.

The Exchange believes the proposal to eliminate the access fees, display fees for professional users, and non-display fees associated with its proprietary market data products for customers that are Federal agencies is reasonable, equitable and not unfairly discriminatory because it is designed to facilitate federal government regulation without giving an undue advantage to one set of commercial users over another. The Exchange believes that it is reasonable to assess no fees to Federal agencies that subscribe to the Exchange's proprietary market data products because Federal agencies do not use the Exchange's proprietary market data for commercial gain, but only for regulatory purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. In setting the proposed fees, the Exchange considered the competitiveness of the market for proprietary data and all of the implications of that competition. The Federal agencies that will benefit from the proposed rule change, however, do not use the Exchange's proprietary market data products for commercial purposes and do not compete with commercial users of the data. The Exchange believes that it has considered all relevant factors and has not considered irrelevant factors in order to establish fair, reasonable, and not unreasonably discriminatory fees and an equitable allocation of fees among all users.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A) [9] of the Act and subparagraph (f)(2) of Rule 19b–4 [10] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of

[1] 15 U.S.C.78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] FAR is the principal set of rules governing the process by which the U.S. federal government purchases goods and services.

[5] *See* 48 CFR 2.101. FAR defines ''Federal agency'' as ''any executive agency or any independent establishment in the legislative or judicial branch of the Government (except the Senate, the House of Representatives, the Architect of the Capitol, and any activities under the Architect's direction).'' ''Executive agency'' is defined as ''an executive department, a military department, or any independent establishment within the meaning of 5 U.S.C. 101, 102, and 104(1), respectively, and any wholly owned Government corporation within the meaning of 31 U.S.C. 9101.''

[6] These products are currently NYSE MKT Integrated Feed, NYSE MKT OpenBook, NYSE MKT BBO, NYSE MKT Trades and NYSE MKT Order Imbalances.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4), (5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B) [11] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–NYSEMKT–2016–32 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEMKT–2016–32. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEMKT–2016–32 and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05119 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[11] 15 U.S.C. 78s(b)(2)(B).

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77285; File No. SR–NASDAQ–2016–029]

Self-Regulatory Organizations; The NASDAQ Stock Market LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend Access Services Fees Under Rule 7015

March 3, 2016.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on February 23, 2016, The NASDAQ Stock Market LLC (''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, II, and III, below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to a proposal to [sic] amend the Exchange's Access Services fees under Rule 7015 to: (i) Assess a $25/port/month Disaster Recovery Port fee applied to FIX Trading Port [sic], OUCH, RASH, and DROP protocol disaster recovery ports; and (ii) assess a $100/port/month fee for Trading Ports used in Test Mode.

The text of the proposed rule change is available on the Exchange's Web site at *http://nasdaq.cchwallstreet.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change to Rule 7015 is to amend the Exchange's Access Services fees under Rule 7015 to: (i) Assess a $25/port/month Disaster Recovery Port fee applied to FIX Trading Port [sic], OUCH, RASH, and DROP protocol disaster recovery ports; and (ii) assess a $100/port/month fee for Trading Ports used in Test Mode.

First Change

The Exchange is in the process of transitioning its Disaster Recovery (''DR'') functionality for the U.S. equities and options markets from Ashburn, VA to its new Chicago, IL data center. The Exchange has invested and installed new equipment in the Chicago data center for client connectivity and for the infrastructure of Exchange systems. The Exchange chose Chicago as the location of its new DR data center as many other exchanges are using this same location for a disaster recovery or a primary location and, as a result, many of our market participants have a presence or connection at this location, thus making it easier and less expensive for many market participants to connect to the Exchange for DR.

Under Rule 7015, member firms may subscribe to DR ports, which provide backup connectivity in the event of a failure or disaster rendering their primary connectivity at Carteret, NJ subscribed to under Rule 7015 unavailable. To date, the Exchange has transitioned its FIX Trading Ports, OUCH, RASH, and DROP Ports to the Chicago center from Ashburn. Currently, the Exchange does not assess a fee for any DR ports.

The Exchange has incurred an initial cost associated with moving DR ports to the Chicago center, including the purchase of upgraded hardware and physical space to house the DR ports, which is more expensive than the Ashburn location. The Exchange also incurs ongoing costs in maintaining the DR ports, including costs incurred maintaining servers and their physical

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

location, monitoring order activity, and other support, which is collectively more expensive in Chicago than Ashburn. Accordingly, the Exchange is proposing to assess a fee of $25 per port, per month for DR Ports used with FIX Trading Ports, OUCH, RASH, and DROP Ports.

Second Change

Under Rule 7015, Member [sic] firms may subscribe to Trading Ports used in Test Mode, which are trading ports available in primary market location in [sic] Carteret, NJ, that are exclusively used for testing purposes, at no cost. These ports may not be used for trading in securities in the System, but rather allow a member firm to test their systems prior to connecting to the live trading environment. Test Ports are identical to trading ports [3] and share the same infrastructure, but are restricted to only allow order entry into the System in test symbols. A member firm may elect to designate a subscribed trading port as either in ''production mode'' or in ''test mode.'' A Trading Port that is in production mode allows a member firm to send orders for execution on the Exchange system in the normal course. When a member firm changes a trading port's status to test mode, the Exchange will not allow normal order activity to occur through the port but rather it limits all order activity to test symbols. Under Rule 7015, member firms are assessed a monthly fee of $550 per port for each trading port subscribed in production mode. Member firms are not currently assessed a fee for Trading Ports used in Test Mode.

The Exchange has audited the use of Trading Ports used in Test Mode and found that a majority of Trading Ports used in Test Mode are not used for testing, but rather remain idle. The Exchange incurs costs associated with maintaining such ports, including costs incurred maintaining servers and their physical location, monitoring order activity, and other support. Accordingly, the Exchange is proposing to assess a fee of $100 per port, per month.[4]

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act [5] in general, and furthers the objectives of Sections 6(b)(4) and 6(b)(5) of the Act [6] in particular, in that it provides for the equitable allocation of reasonable dues, fees and other charges among members and issuers and other persons using any facility or system which the Exchange operates or controls, and is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

The Commission and the courts have repeatedly expressed their preference for competition over regulatory intervention in determining prices, products, and services in the securities markets. In Regulation NMS, while adopting a series of steps to improve the current market model, the Commission highlighted the importance of market forces in determining prices and SRO revenues and, also, recognized that current regulation of the market system ''has been remarkably successful in promoting market competition in its broader forms that are most important to investors and listed companies.'' [7] Likewise, in *NetCoalition* v. *Securities and Exchange Commission* [8] (''NetCoalition'') the D.C. Circuit upheld the Commission's use of a market-based approach in evaluating the fairness of market data fees against a challenge claiming that Congress mandated a cost-based approach.[9] As the court emphasized, the Commission ''intended in Regulation NMS that 'market forces, rather than regulatory requirements' play a role in determining the market data . . . to be made available to investors and at what cost.'' [10]

Further, ''[n]o one disputes that competition for order flow is 'fierce.' . . . As the SEC explained, '[i]n the U.S. national market system, buyers and sellers of securities, and the broker-dealers that act as their order-routing agents, have a wide range of choices of where to route orders for execution'; [and] 'no exchange can afford to take its market share percentages for granted' because 'no exchange possesses a monopoly, regulatory or otherwise, in the execution of order flow from broker dealers'. . . .'' [11]

DR Port Fees

The fee assessed for DR Ports used with FIX Trading Ports, OUCH, RASH, and DROP ports is reasonable because it is based on the cost incurred by the Exchange in purchasing and maintaining DR ports in the Chicago data center.

The Exchange does not currently have a means to recoup its investment and costs associated with providing member firms with DR ports in the Chicago data center. Thus, the Exchange believes that the proposed fee is reasonable because the fee is intended to cover the Exchange's costs incurred in maintaining DR ports. The proposed fee may also allow the Exchange to make a profit to the extent the costs associated with purchasing and maintaining DR ports are covered.

The Exchange believes that the proposed fee is equitably allocated and not unfairly discriminatory because it will apply equally to all subscribers to DR ports based on the number of ports subscribed. Last, the Exchange notes that, for most member firms, subscription to DR ports is voluntary, and member firms may subscribe to as many or as few ports they believe is necessary. A select number of member firms chosen by the Exchange to participate in business continuity and disaster recovery plan testing pursuant to Rule 1170 will be obligated to subscribe to a DR port to participate in the annual test. Although subscription to DR ports is not voluntary for member firms selected for this once a year test, the Exchange believes that assessing the proposed fee is an equitable allocation and not unfairly discriminatory because such member firms will derive the same benefit as those members that voluntarily elect to subscribe to DR ports and such members may cancel their DR port subscription once their Rule 1170 testing obligation is satisfied.

Trading Ports Used in Test Mode Fees

The proposed fee is also reasonable because it is based on the cost incurred by the Exchange in developing and maintaining multiple port connections, which are not used in the production environment and are designated as in test mode. As noted, the Exchange invests time and capital in initiating, monitoring and maintaining port connections to its system. Currently, the Exchange does not have a means to

[3] *E.g.,* FIX, RASH, and OUCH.

[4] The Exchange bills Access Services subscriptions by prorating the first monthly fee by the number of days that subscription was subscribed and thereafter assesses the full monthly fee, including the full month in which the subscription is cancelled. If a subscriber elects to change a test mode port to a production port in a given month, the Exchange will assess the Trading Ports used in Test Mode fee, which may be prorated if subscribed to in the same month, and will also assess the production port fee, which will be prorated from the date the change is made through the end of the month. Likewise, if a subscriber elects to change a production mode port to a test mode port in a given month, the Exchange will assess the monthly production port fee, which may be prorated if subscribed to in the same month, and will also assess the Trading Ports used in Test Mode fee, which will be prorated from the date the change is made through the end of the month.

[5] 15 U.S.C. 78f(b).

[6] 15 U.S.C. 78f(b)(4) and (5).

[7] Securities Exchange Act Release No. 51808 at 37499 (June 9, 2005) (''Regulation NMS Adopting Release'') [sic].

[8] *NetCoalition* v. *SEC,* 615 F.3d 525 (D.C. Cir. 2010).

[9] *See NetCoalition,* at 534.

[10] *Id.* at 537.

[11] *Id.* at 539 (quoting ArcaBook Order, 73 FR at 74782–74783 [sic]).

recoup its investment and costs associated with providing member firms with Trading Ports used in Test Mode. Thus, the Exchange believes that the proposed fee is reasonable because the fee is intended to cover the Exchange's costs incurred in maintaining test mode ports and is less than what is charged for a trading port in production mode. The proposed fee may also allow the Exchange to make a profit to the extent the costs associated with developing and maintaining Trading Ports used in Test Mode are covered.

The Exchange believes that the proposed fee does not discriminate unfairly as it will promote efficiency in the market by incentivizing member firms to either place idle ports into production or cancel them if unneeded. The Exchange believes the proposed fee is equitably allocated because all Exchange member firms that voluntarily elect to subscribe to trading ports, yet maintain them in test mode, will be charged the fee equally on a per-port basis. Last, the Exchange notes that subscription to Trading Ports used in Test Mode is voluntary, and member firms may subscribe to as many or as few ports they believe is necessary for their testing purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. In terms of inter-market competition, the Exchange notes that it operates in a highly competitive market in which market participants can readily favor competing venues if they deem fee levels at a particular venue to be excessive, or rebate opportunities available at other venues to be more favorable. In such an environment, the Exchange must continually adjust its fees to remain competitive with other exchanges and with alternative trading systems that have been exempted from compliance with the statutory standards applicable to exchanges. Because competitors are free to modify their own fees in response, and because market participants may readily adjust their order routing practices, the Exchange believes that the degree to which fee changes in this market may impose any burden on competition is extremely limited. In this instance, the proposed fee merely allows the Exchange to recapture the costs associated with maintaining member ports that are in test mode and DR, and may provide the Exchange with a profit to the extent its costs are covered. The Trading Port used in Test Mode fee is applied uniformly to member firms that have such ports in the Carteret data center, where the Exchange incurs expenses to support this port configuration option. The proposed fee will also promote efficient use of Trading Ports for testing.

Similarly, the Exchange incurs greater costs in offering DR ports in the new Chicago data center, which the Exchange is seeking to cover. Any burden arising from the fees is necessary to cover costs associated with the location of the functionality in Chicago. If the changes proposed herein are unattractive to market participants, it is likely that the Exchange will lose market share as a result as member firms chose [sic] one of many alternative venues on which they may trade. Accordingly, the Exchange does not believe that the proposed changes will impair the ability of members or competing order execution venues to maintain their competitive standing in the financial markets.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act.[12]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is: (i) Necessary or appropriate in the public interest; (ii) for the protection of investors; or (iii) otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–NASDAQ–2016–029 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASDAQ–2016–029. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASDAQ–2016–029 and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[13]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05125 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[12] 15 U.S.C. 78s(b)(3)(A)(ii).

[13] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77274; File No. SR–NYSEARCA–2016–35]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change to the NYSE Arca Equities Schedule of Fees and Charges for Exchange Services

March 2, 2016.

Pursuant to section 19(b)(1) [1] of the Securities Exchange Act of 1934 (''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on February 19, 2016, NYSE Arca, Inc. (the ''Exchange'' or ''NYSE Arca'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the NYSE Arca Equities Schedule of Fees and Charges for Exchange Services. The proposed rule change is available on the Exchange's Web site at *www.nyse.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the Fee Schedule to make non-substantive changes by deleting obsolete and extraneous text. The Exchange proposes to implement the proposed changes immediately.

The Exchange currently charges each ETP Holder a monthly Gross FOCUS Fee of $0.075 per $1,000 of gross revenue reported on its FOCUS Report.[4] The Exchange last amended this fee in 2013.[5] The Exchange proposes to re-align the text in the Fee Schedule to clearly reflect the current fee and the frequency of the fee by deleting extraneous text from the Fee Schedule. The Exchange is not proposing any change to the fee itself.

Additionally, the Fee Schedule currently provides for a variable pass through charge for subscription of the RealTick financial software (''RealTick''). The Exchange last amended this fee in 2011 [sic].[6] The Exchange no longer offers or supports subscription to RealTick and therefore, proposes to remove this fee from the Fee Schedule.

The proposed changes are not otherwise intended to address any other issues, and the Exchange is not aware of any significant problems that market participants would have in complying with the proposed changes.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with section 6(b) of the Act,[7] in general, and furthers the objectives of sections 6(b)(4) and (5) of the Act,[8] in particular, because it provides for the equitable allocation of reasonable dues, fees, and other charges among its members, issuers and other persons using its facilities and does not unfairly discriminate between customers, issuers, brokers or dealers.

The Exchange believes that the proposed re-alignment of the Gross FOCUS Fee and the proposed removal of the RealTick fee from the Fee Schedule will remove investor confusion. The Exchange strives for clarity in the Fee Schedule so that market participants may best understand how fees apply. The Exchange believes the proposed changes will add clarity to the Fee Schedule and alleviate potential confusion which will remove impediments to and perfect the mechanism of a free and open market and a national market system, and in general, protect investors and the public interest. The Exchange further believes that the proposed changes are designed to enable market participants to better understand how Exchange fees would be applicable, which should make the overall Fee Schedule more transparent and comprehensive to the benefit of the investing public.

For the foregoing reasons, the Exchange believes that the proposal is consistent with the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will [sic] any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The proposed change is not designed to address any competitive issue but rather provide the public and investors with a Fee Schedule that is clear and transparent.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to section 19(b)(3)(A) [9] of the Act and subparagraph (f)(2) of Rule 19b–4 [10] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under section 19(b)(2)(B) [11] of the Act to determine whether the proposed rule change should be approved or disapproved.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] FOCUS is an acronym for Financial and Operational Combined Uniform Single Report. FOCUS Reports are filed periodically with the Securities and Exchange Commission (the ''Commission'' or ''SEC'') as SEC Form X–17A–5 pursuant to Rule 17a–5 under the Act.

[5] *See* Securities Exchange Act Release Nos. [sic] 69059 (March 7, 2013), 78 FR 16019 (March 13, 2013) (SR–NYSEArca–2013–23).

[6] *See* Securities Exchange Act Release Nos. [sic] 57221 (January 29, 2008), 73 FR 6764 (February 5, 2008) (SR–NYSEArca–2008–11).

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4) and (5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

[11] 15 U.S.C. 78s(b)(2)(B).

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSEARCA–2016–35 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEARCA–2016–35. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEARCA–2016–35 and should be submitted on or before March 29, 2016.

[12] 17 CFR 200.30–3(a)(12).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05046 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–32018; File No. 812–14454]

Crescent Capital BDC Inc., et al.; Notice of Application

March 2, 2016.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of application for an order under sections 17(d) and 57(i) of the Investment Company Act of 1940 (the ''Act'') and rule 17d–1 under the Act to permit certain joint transactions otherwise prohibited by sections 17(d) and 57(a)(4) of the Act and rule 17d–1 under the Act.

SUMMARY: *Summary of Application:* Applicants request an order to permit a business development company (''BDC'') and certain closed-end management investment companies to co-invest in portfolio companies with each other and with affiliated investment funds.

Applicants: Crescent Capital BDC, Inc. (''Crescent''); CBDC Advisors, LLC (''CBDC Advisors''); Crescent Mezzanine Partners VI, LP, Crescent Mezzanine Partners VIB, LP, Crescent Mezzanine Partners VIC, LP, Crescent Long/Short Credit Opportunity Fund, LP, Crescent Capital High Income Fund, LP, Crescent Capital High Income Fund B, L.P., Crescent Capital High Yield Fund, LP, Crescent Senior Secured Floating Rate Loan Fund, LLC, Crescent Senior Secured Floating Rate Loan Fund (Cayman), LP, Crescent/Kamehameha Schools Partnership, LP, NPS/Crescent Strategic Partnership, LP, Crescent (TX) Direct Lending Fund, L.P., Crescent Direct Lending Fund, L.P., CDL Unit Trust (Ireland), Crescent Direct Lending SBIC Fund, L.P., Crescent Special Situations Fund (Investor Group), L.P., Crescent European Specialty Lending Fund, L.P., Crescent European Specialty Loan Fund SCS, SICAV–FIS, Crescent European Specialty Lending Fund (Levered) LP, Crescent European Specialty Lending Fund (Cayman-Levered) LP, Crescent European Specialty Lending Fund (Cayman) LP, Crescent European Specialty Lending Fund for ERISA Plans LP, Crescent Mezzanine Partners VII (Ltl), L.P., Crescent Mezzanine Partners VII, L.P., Crescent Mezzanine Partners VIIB, L.P., Crescent Mezzanine Partners VIIC (LTL), L.P., Crescent Mezzanine Partners VIIC, L.P., and Crescent/AEGIS Partnership, L.P. (collectively, the ''Existing Affiliated Funds''); Crescent Capital Group LP (''Crescent Capital''); and Crescent Direct Lending Management, LLC, Crescent SBIC Management, LLC, and Crescent Credit Europe LLP (collectively with Crescent Capital, the ''Existing Crescent Advisers'').

DATES: *Filing Dates:* The application was filed on April 15, 2015, and amended on June 25, 2015, August 18, 2015, November 18, 2015, February 26, 2016, and March 1, 2016.

Hearing or Notification of Hearing: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on March 28, 2016, and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Pursuant to Rule 0–5 under the Act, hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, U.S. Securities and Exchange Commission, 100 F St. NE., Washington, DC 20549–1090. Applicants: 11100 Santa Monica Blvd., Suite 2000, Los Angeles, CA 90025.

FOR FURTHER INFORMATION CONTACT: Mark N. Zaruba, Senior Counsel, at (202) 551–6878 or Mary Kay Frech, Branch Chief, at (202) 551–6821 (Chief Counsel's Office, Division of Investment Management).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site by searching for the file number, or for an applicant using the Company name box, at *http://www.sec.gov/search/search.htm* or by calling (202) 551–8090.

Applicants' Representations

1. Crescent is a Delaware corporation organized as a closed-end management investment company that has elected to be regulated as a BDC under section

54(a) of the Act.[1] Crescent's investment objective is to maximize the total return to its stockholders in the form of current income and capital appreciation. Crescent's primary focus is originating and investing primarily in secured debt (including senior secured, unitranche and second lien debt) and unsecured debt (including senior unsecured and subordinated debt), as well as related equity securities of private U.S. middle-market companies. The board of directors (''Board'') of Crescent has five members, three of which members are not ''interested persons'' as defined in section 2(a)(19) of the Act (''Independent Directors'').[2]

2. CBDC Advisors is a Delaware limited liability company and is an investment adviser registered with the Commission under the Investment Advisers Act of 1940 (''Advisers Act''). CBDC Advisors serves as the investment adviser to Crescent, which is currently CBDC Advisors' sole client.

3. Crescent Capital is a limited partnership organized under the Delaware Revised Uniform Limited Partnership Act, Crescent Direct Lending Management, LLC and Crescent SBIC Management, LLC are each Delaware limited liability companies, and Crescent Credit Europe LLP is a limited liability partnership organized in England and Wales. Each Existing Crescent Adviser is registered as an investment adviser under the Advisers Act.

4. The Existing Affiliated Funds pursue strategies focused on originating and investing primarily in secured debt (including senior secured, unitranche and second lien debt) and unsecured debt (including senior unsecured and subordinated debt), as well as related equity securities of private U.S. middle-market companies. Each Existing Affiliated Fund is advised by a Crescent Adviser[3] and would be an investment company but for section 3(c)(1) or 3(c)(7) of the Act.

5. Applicants seek an order (''Order'') to permit a Regulated Entity[4] and one or more other Regulated Entities and one or more Affiliated Funds[5] to (a) participate in the same investment opportunities through a proposed co-investment program where such participation would otherwise be prohibited under sections 17 and 57 of the Act; and (b) make additional investments in securities of such issuers (''Follow-On Investments''), including through the exercise of warrants, conversion privileges, and other rights to purchase securities of the issuers. ''Co-Investment Transaction'' means any transaction in which a Regulated Entity (or its Wholly-Owned Investment Subsidiary, as defined below) participated together with one or more other Regulated Entities and/or Affiliated Funds in reliance on the requested Order. ''Potential Co-Investment Transaction'' means any investment opportunity in which a Regulated Entity (or its Wholly-Owned Investment Subsidiary) seeks to participate together with one or more other Regulated Entities and/or Affiliated Funds in reliance on the Order.[6]

6. Applicants state that a Regulated Entity may, from time to time, form a Wholly-Owned Investment Subsidiary.[7] Such a subsidiary would be prohibited from investing in a Co-Investment Transaction with any other Regulated Entity or Affiliated Fund because it would be a company controlled by its parent Regulated Entity for purposes of section 57(a)(4) and rule 17d–1. Applicants request that each Wholly-Owned Investment Subsidiary be permitted to participate in Co-Investment Transactions in lieu of its parent Regulated Entity and that the Wholly-Owned Investment Subsidiary's participation in any such transaction be treated, for purposes of the Order, as though the parent Regulated Entity were participating directly. Applicants represent that this treatment is justified because a Wholly-Owned Investment Subsidiary would have no purpose other than serving as a holding vehicle for the Regulated Entity's investments and, therefore, no conflicts of interest could arise between the Regulated Entity and the Wholly-Owned Investment Subsidiary. The Regulated Entity's Board would make all relevant determinations under the conditions with regard to a Wholly-Owned Investment Subsidiary's participation in a Co-Investment Transaction, and the Regulated Entity's Board would be informed of, and take into consideration, any proposed use of a Wholly-Owned Investment Subsidiary in the Regulated Entity's place. If the Regulated Entity proposes to participate in the same Co-Investment Transaction with any of its Wholly-Owned Investment Subsidiaries, the Board will also be informed of, and take into consideration, the relative participation of the Regulated Entity and the Wholly-Owned Investment Subsidiary.

7. When considering Potential Co-Investment Transactions for any Regulated Entity, the relevant Adviser[8] will consider only the Objectives and Strategies,[9] investment policies, investment positions, capital available for investment, and other pertinent factors applicable to that Regulated Entity. CBDC Advisors expects that any portfolio company that is an appropriate investment for a Regulated Entity should also be an appropriate investment for one or more other Regulated Entities and/or one or more

[1] Section 2(a)(48) defines a BDC to be any closed-end investment company that operates for the purpose of making investments in securities described in sections 55(a)(1) through 55(a)(3) of the Act and makes available significant managerial assistance with respect to the issuers of such securities.

[2] The term ''Independent Directors'' refers to the independent directors or trustees of any Regulated Entity (defined below).

[3] ''Crescent Adviser'' means any Existing Crescent Adviser or any future investment adviser that controls, is controlled by, or is under common control with Crescent Capital and is registered as an investment adviser under the Advisers Act.

[4] ''Regulated Entity'' refers to Crescent and the Future Regulated Entities. ''Future Regulated Entity'' means any closed-end management investment company whose investment adviser is the CBDC Advisors or any future investment adviser that controls, is controlled by, or is under common control with CBDC Advisors and is registered as an investment adviser under the Advisers Act (each such investment adviser, a ''Regulated Entity Adviser'').

[5] ''Affiliated Fund'' means any Existing Affiliated Fund or any Future Affiliated Fund. ''Future Affiliated Fund'' means any investment fund that would be an ''investment company'' but for section 3(c)(1) or 3(c)(7) of the Act, is formed in the future, and is advised by a Crescent Adviser. No Affiliated Fund is or will be a subsidiary of a Regulated Entity.

[6] All existing entities that currently intend to rely upon the requested Order have been named as applicants. Any other existing or future entity that subsequently relies on the Order will comply with the terms and conditions of the application.

[7] The term ''Wholly-Owned Investment Subsidiary'' means an entity: (a) That is wholly-owned by a Regulated Entity (with such Regulated Entity at all times holding, beneficially and of record, 100% of the voting and economic interests); (b) whose sole business purpose is to hold one or more investments on behalf of such Regulated Entity (and, in the case of an entity that is licensed by the Small Business Administration to operate under the Small Business Investment Act of 1958, as amended (the ''SBA Act''), as a small business investment company, to maintain a license under the SBA Act and issue debentures guaranteed by the Small Business Administration); (c) with respect to which the board of directors of such Regulated Entity has the sole authority to make all determinations with respect to the entity's participation under the conditions of the application; and (d) that would be an investment company but for section 3(c)(1) or 3(c)(7) of the Act. All subsidiaries participating in Co-Investment Transactions will be Wholly-Owned Investment Subsidiaries and will have Objectives and Strategies (as defined below) that are either the same as, or a subset of, their parent Regulated Entity's Objectives and Strategies.

[8] The term ''Adviser'' means any Crescent Adviser or any Regulated Entity Adviser.

[9] The term ''Objectives and Strategies'' means a Regulated Entity's investment objectives and strategies as described in the Regulated Entity's registration statement on Form 10, other filings the Regulated Entity has made with the Commission under the Securities Act of 1933 (the ''Securities Act'') or the Securities Exchange Act of 1934, and the Regulated Entity's reports to shareholders.

Affiliated Funds, with certain exceptions based on available capital or diversification.[10]

8. Other than pro rata dispositions and Follow-On Investments as provided in conditions 7 and 8, and after making the determinations required in conditions 1 and 2(a), the applicable Adviser will present each Potential Co-Investment Transaction and the proposed allocation to the directors of the Board eligible to vote under section 57(o) of the Act (''Eligible Directors''), and the ''required majority,'' as defined in section 57(o) of the Act (''Required Majority'')[11] will approve each Co-Investment Transaction prior to any investment by the participating Regulated Entity.

9. With respect to the pro rata dispositions and Follow-On Investments provided in conditions 7 and 8, a Regulated Entity may participate in a pro rata disposition or Follow-On Investment without obtaining prior approval of the Required Majority if, among other things: (i) The proposed participation of each Regulated Entity and each Affiliated Fund in such disposition is proportionate to its outstanding investments in the issuer immediately preceding the disposition or Follow-On Investment, as the case may be; and (ii) the Board of the Regulated Entity has approved that Regulated Entity's participation in pro rata dispositions and Follow-On Investments as being in the best interests of the Regulated Entity. If the Board does not so approve, any such disposition or Follow-On Investment will be submitted to the Regulated Entity's Eligible Directors. The Board of any Regulated Entity may at any time rescind, suspend or qualify its approval of pro rata dispositions and Follow-On Investments with the result that all dispositions and/or Follow-On Investments must be submitted to the Eligible Directors.

10. No Independent Director of a Regulated Entity will have a direct or indirect financial interest in any Co-Investment Transaction (other than indirectly through share ownership in one of the Regulated Entities), including any interest in any company whose securities would be acquired in a Co-Investment Transaction.

11. Under condition 14, if an Adviser, its principals, or any person controlling, controlled by, or under common control with the Adviser or its principals, and the Affiliated Funds (collectively, the ''Holders'') own in the aggregate more than 25 percent of the outstanding voting shares of a Regulated Entity (the ''Shares''), then the Holders will vote such Shares as directed by an independent third party when voting on matters specified in the condition. Applicants believe that this condition will ensure that the Independent Directors will act independently in evaluating the co-investment program, because the ability of an Adviser or its principals to influence the Independent Directors by a suggestion, explicit or implied, that the Independent Directors can be removed will be limited significantly. Applicants represent that the Independent Directors will evaluate and approve any such independent third party, taking into account its qualifications, reputation for independence, cost to the Regulated Entity's shareholders, and other factors that they deem relevant.

[10] The Regulated Entities, however, will not be obligated to invest, or co-invest, when investment opportunities are referred to them.

[11] In the case of a Regulated Entity that is a registered closed-end fund, the Board members that make up the Required Majority will be determined as if the Regulated Entity were a BDC subject to section 57(o).

Applicants' Legal Analysis

1. Section 57(a)(4) of the Act prohibits certain affiliated persons of a BDC from participating in joint transactions with the BDC or a company controlled by a BDC in contravention of rules as prescribed by the Commission. In particular, section 57(a)(4) applies to any person who is directly or indirectly controlling, controlled by, or under common control with a BDC is subject to section 57(a)(4). Applicants submit that each of the Regulated Entities and Affiliated Funds could be deemed to be a person related to each Regulated Entity in a manner described by section 57(b) by virtue of being under common control. Section 57(i) of the Act provides that, until the Commission prescribes rules under section 57(a)(4), the Commission's rules under section 17(d) of the Act applicable to registered closed-end investment companies will be deemed to apply to transactions subject to section 57(a)(4). Because the Commission has not adopted any rules under section 57(a)(4), rule 17d–1 also applies to joint transactions with Regulated Entities that are BDCs. Section 17(d) of the Act and rule 17d–1 under the Act are applicable to Regulated Entities that are registered closed-end investment companies.

2. Section 17(d) of the Act and rule 17d-1 under the Act prohibit affiliated persons of a registered investment company from participating in joint transactions with the company unless the Commission has granted an order permitting such transactions. In passing upon applications under rule 17d–1, the Commission considers whether the company's participation in the joint transaction is consistent with the provisions, policies, and purposes of the Act and the extent to which such participation is on a basis different from or less advantageous than that of other participants.

3. Applicants state that in the absence of the requested relief, the Regulated Entities would be, in some circumstances, limited in their ability to participate in attractive and appropriate investment opportunities. Applicants believe that the proposed terms and conditions will ensure that the Co-Investment Transactions are consistent with the protection of each Regulated Entity's shareholders and with the purposes intended by the policies and provisions of the Act. Applicants state that the Regulated Entities' participation in the Co-Investment Transactions will be consistent with the provisions, policies, and purposes of the Act and on a basis that is not different from or less advantageous than that of other participants.

Applicants' Conditions

Applicants agree that the Order will be subject to the following conditions:

1. Each time an Adviser considers a Potential Co-Investment Transaction for another Regulated Entity or an Affiliated Fund that falls within a Regulated Entity's then-current Objectives and Strategies, the Regulated Entity's Adviser will make an independent determination of the appropriateness of the investment for the Regulated Entity in light of the Regulated Entity's then-current circumstances.

2. (a) If the Adviser deems a Regulated Entity's participation in any Potential Co-Investment Transaction to be appropriate for the Regulated Entity, the Adviser will then determine an appropriate level of investment for the Regulated Entity.

(b) If the aggregate amount recommended by the applicable Adviser to be invested by the applicable Regulated Entity in the Potential Co-Investment Transaction together with the amount proposed to be invested by the other participating Regulated Entities and Affiliated Funds, collectively, in the same transaction, exceeds the amount of the investment opportunity, the investment opportunity will be allocated among them pro rata based on each participant's capital available for investment in the asset class being allocated, up to the amount proposed to be invested by each. The applicable Adviser will provide the Eligible Directors of each participating Regulated Entity with information

concerning each participating party's available capital to assist the Eligible Directors with their review of the Regulated Entity's investments for compliance with these allocation procedures.

(c) After making the determinations required in conditions 1 and 2(a), the applicable Adviser will distribute written information concerning the Potential Co-Investment Transaction (including the amount proposed to be invested by each Regulated Entity and each Affiliated Fund) to the Eligible Directors of each participating Regulated Entity for their consideration. A Regulated Entity will co-invest with another Regulated Entity or an Affiliated Fund only if, prior to the Regulated Entity's participation in the Potential Co-Investment Transaction, a Required Majority concludes that:

(i) the terms of the Potential Co-Investment Transaction, including the consideration to be paid, are reasonable and fair to the Regulated Entity and its shareholders and do not involve overreaching in respect of the Regulated Entity or its shareholders on the part of any person concerned;

(ii) the Potential Co-Investment Transaction is consistent with:

(A) the interests of the Regulated Entity's shareholders; and

(B) the Regulated Entity's then-current Objectives and Strategies;

(iii) the investment by any other Regulated Entities or any Affiliated Funds would not disadvantage the Regulated Entity, and participation by the Regulated Entity would not be on a basis different from or less advantageous than that of any other Regulated Entities or any Affiliated Funds; provided that, if any other Regulated Entity or any Affiliated Fund, but not the Regulated Entity itself, gains the right to nominate a director for election to a portfolio company's board of directors or the right to have a board observer or any similar right to participate in the governance or management of the portfolio company, such event shall not be interpreted to prohibit the Required Majority from reaching the conclusions required by this condition (2)(c)(iii), if:

(A) the Eligible Directors will have the right to ratify the selection of such director or board observer, if any; and

(B) the applicable Adviser agrees to, and does, provide periodic reports to the Board of the Regulated Entity with respect to the actions of such director or the information received by such board observer or obtained through the exercise of any similar right to participate in the governance or management of the portfolio company; and

(C) any fees or other compensation that any Regulated Entity or any Affiliated Fund or any affiliated person of any Regulated Entity or any Affiliated Fund receives in connection with the right of a Regulated Entity or an Affiliated Fund to nominate a director or appoint a board observer or otherwise to participate in the governance or management of the portfolio company will be shared proportionately among the participating Affiliated Funds (who may each, in turn, share its portion with its affiliated persons) and the participating Regulated Entities in accordance with the amount of each party's investment; and

(iv) the proposed investment by the Regulated Entity will not benefit any Adviser, the other Regulated Entities, the Affiliated Funds or any affiliated person of any of them (other than the parties to the Co-Investment Transaction), except (A) to the extent permitted by condition 13, (B) to the extent permitted by section 17(e) or 57(k) of the Act, as applicable, (C) indirectly, as a result of an interest in the securities issued by one of the parties to the Co-Investment Transaction, or (D) in the case of fees or other compensation described in condition 2(c)(iii)(C).

3. Each Regulated Entity has the right to decline to participate in any Potential Co-Investment Transaction or to invest less than the amount proposed.

4. The applicable Adviser will present to the Board of each Regulated Entity, on a quarterly basis, a record of all investments in Potential Co-Investment Transactions made by any of the other Regulated Entities or Affiliated Funds during the preceding quarter that fell within the Regulated Entity's then-current Objectives and Strategies that were not made available to the Regulated Entity, and an explanation of why the investment opportunities were not offered to the Regulated Entity. All information presented to the Board pursuant to this condition will be kept for the life of the Regulated Entity and at least two years thereafter, and will be subject to examination by the Commission and its staff.

5. Except for Follow-On Investments made in accordance with condition 8,[12] a Regulated Entity will not invest in reliance on the Order in any issuer in which another Regulated Entity, Affiliated Fund, or any affiliated person of another Regulated Entity or Affiliated Fund is an existing investor.

6. A Regulated Entity will not participate in any Potential Co-Investment Transaction unless the terms, conditions, price, class of securities to be purchased, settlement date, and registration rights will be the same for each participating Regulated Entity and Affiliated Fund. The grant to another Regulated Entity or an Affiliated Fund, but not the Regulated Entity, of the right to nominate a director for election to a portfolio company's board of directors, the right to have an observer on the board of directors or similar rights to participate in the governance or management of the portfolio company will not be interpreted so as to violate this condition 6, if conditions 2(c)(iii)(A), (B) and (C) are met.

7. (a) If any Regulated Entity or an Affiliated Fund elects to sell, exchange or otherwise dispose of an interest in a security that was acquired in a Co-Investment Transaction, the applicable Adviser will:

(i) notify each Regulated Entity that participated in the Co-Investment Transaction of the proposed disposition at the earliest practical time; and

(ii) formulate a recommendation as to participation by each Regulated Entity in the disposition.

(b) Each Regulated Entity will have the right to participate in such disposition on a proportionate basis, at the same price and on the same terms and conditions as those applicable to the participating Regulated Entities and Affiliated Funds.

(c) A Regulated Entity may participate in such disposition without obtaining prior approval of the Required Majority if: (i) The proposed participation of each Regulated Entity and each Affiliated Fund in such disposition is proportionate to its outstanding investments in the issuer immediately preceding the disposition; (ii) the Board of the Regulated Entity has approved as being in the best interests of the Regulated Entity the ability to participate in such dispositions on a pro rata basis (as described in greater detail in the application); and (iii) the Board of the Regulated Entity is provided on a quarterly basis with a list of all dispositions made in accordance with this condition. In all other cases, the Adviser will provide its written recommendation as to the Regulated Entity's participation to the Regulated Entity's Eligible Directors, and the Regulated Entity will participate in such disposition solely to the extent that a Required Majority determines that it is in the Regulated Entity's best interests.

[12] This exception applies only to Follow-On Investments by a Regulated Entity in issuers in which that Regulated Entity already holds investments.

(d) Each Regulated Entity and each Affiliated Fund will bear its own expenses in connection with any such disposition.

8. (a) If a Regulated Entity or an Affiliated Fund desires to make a Follow-On Investment in a portfolio company whose securities were acquired in a Co-Investment Transaction, the applicable Adviser will:

(i) notify each Regulated Entity that participated in the Co-Investment Transaction of the proposed transaction at the earliest practical time; and

(ii) formulate a recommendation as to the proposed participation, including the amount of the proposed Follow-On Investment, by each Regulated Entity.

(b) A Regulated Entity may participate in such Follow-On Investment without obtaining prior approval of the Required Majority if: (i) The proposed participation of each Regulated Entity and each Affiliated Fund in such investment is proportionate to its outstanding investments in the issuer immediately preceding the Follow-On Investment; and (ii) the Board of the Regulated Entity has approved as being in the best interests of the Regulated Entity the ability to participate in Follow-On Investments on a pro rata basis (as described in greater detail in the application). In all other cases, the Adviser will provide its written recommendation as to the Regulated Entity's participation to the Eligible Directors, and the Regulated Entity will participate in such Follow-On Investment solely to the extent that a Required Majority determines that it is in the Regulated Entity's best interests.

(c) If, with respect to any Follow-On Investment:

(i) the amount of a Follow-On Investment is not based on the Regulated Entities' and the Affiliated Funds' outstanding investments immediately preceding the Follow-On Investment; and

(ii) the aggregate amount recommended by the Adviser to be invested by each Regulated Entity in the Follow-On Investment, together with the amount proposed to be invested by the participating Affiliated Funds in the same transaction, exceeds the amount of the opportunity; then the amount invested by each such party will be allocated among them pro rata based on each party's capital available for investment in the asset class being allocated, up to the amount proposed to be invested by each.

(d) The acquisition of Follow-On Investments as permitted by this condition will be considered a Co-Investment Transaction for all purposes and subject to the other conditions set forth in the application.

9. The Independent Directors of each Regulated Entity will be provided quarterly for review all information concerning Potential Co-Investment Transactions and Co-Investment Transactions, including investments made by other Regulated Entities and the Affiliated Funds that the Regulated Entity considered but declined to participate in, so that the Independent Directors may determine whether all investments made during the preceding quarter, including those investments which the Regulated Entity considered but declined to participate in, comply with the conditions of the Order. In addition, the Independent Directors will consider at least annually the continued appropriateness for the Regulated Entity of participating in new and existing Co-Investment Transactions.

10. Each Regulated Entity will maintain the records required by section 57(f)(3) of the Act as if each of the Regulated Entities were a business development company and each of the investments permitted under these conditions were approved by the Required Majority under section 57(f) of the Act.

11. No Independent Director of a Regulated Entity will also be a director, general partner, managing member or principal, or otherwise an ''affiliated person'' (as defined in the Act) of an Affiliated Fund.

12. The expenses, if any, associated with acquiring, holding or disposing of any securities acquired in a Co-Investment Transaction (including, without limitation, the expenses of the distribution of any such securities registered for sale under the Securities Act) will, to the extent not payable by an Adviser under the investment advisory agreements with the Regulated Entities and the Affiliated Funds, be shared by the Affiliated Funds and the Regulated Entities in proportion to the relative amounts of the securities held or to be acquired or disposed of, as the case may be.

13. Any transaction fee [13] (including break-up or commitment fees but excluding broker's fees contemplated by section 17(e) or 57(k) of the Act, as applicable), received in connection with a Co-Investment Transaction will be distributed to the participating Regulated Entities and Affiliated Funds on a pro rata basis based on the amounts they invested or committed, as the case may be, in such Co-Investment Transaction. If any transaction fee is to be held by the Adviser pending consummation of the transaction, the fee will be deposited into an account maintained by the Adviser at a bank or banks having the qualifications prescribed in section 26(a)(1) of the Act, and the account will earn a competitive rate of interest that will also be divided pro rata among the participating Regulated Entities and Affiliated Funds based on the amounts they invest in such Co-Investment Transaction. None of the Affiliated Funds, the Advisers, the other Regulated Entities or any affiliated person of the Regulated Entities or Affiliated Funds will receive additional compensation or remuneration of any kind as a result of or in connection with a Co-Investment Transaction (other than (a) in the case of the Regulated Entities and the Affiliated Funds, the pro rata transaction fees described above and fees or other compensation described in condition 2(c)(iii)(C); and (b) in the case of the Advisers, investment advisory fees paid in accordance with the agreements between the Advisers and the Regulated Entities or the Affiliated Funds).

14. If the Holders own in the aggregate more than 25 percent of the Shares of a Regulated Entity, then the Holders will vote such Shares as directed by an independent third party when voting on (a) the election of directors; (b) the removal of one or more directors; or (c) all other matters under either the Act or applicable State law affecting the Board's composition, size or manner of election.

For the Commission, by the Division of Investment Management, under delegated authority.

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05106 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[13] Applicants are not requesting and the staff is not providing any relief for transaction fees received in connection with any Co-Investment Transaction.

SECURITIES AND EXCHANGE COMMISSION

[SEC File No. 270–297, OMB Control No. 3235–0336]

Submission for OMB Review; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE., Washington, DC 20549–2736.

Extension:

Form N–14.

Notice is hereby given that, under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) (''Paperwork Reduction Act''), the Securities and Exchange Commission (the ''Commission'') has submitted to the Office of Management and Budget (''OMB'') a request for extension of the previously approved collection of information discussed below.

Form N–14 (17 CFR 239.23) is the form for registration under the Securities Act of 1933 (15 U.S.C. 77a *et seq.*) (''Securities Act'') of securities issued by management investment companies registered under the Investment Company Act of 1940 (15 U.S.C. 80a–1 *et seq.*) (''Investment Company Act'') and business development companies as defined by Section 2(a)(48) of the Investment Company Act in: (1) A transaction of the type specified in rule 145(a) under the Securities Act (17 CFR 230.145(a)); (2) a merger in which a vote or consent of the security holders of the company being acquired is not required pursuant to applicable state law; (3) an exchange offer for securities of the issuer or another person; (4) a public reoffering or resale of any securities acquired in an offering registered on Form N–14; or (5) two or more of the transactions listed in (1) through (4) registered on one registration statement. The principal purpose of Form N–14 is to make material information regarding securities to be issued in connection with business combination transactions available to investors. The information required to be filed with the Commission permits verification of compliance with securities law requirements and assures the public availability and dissemination of such information. Without the registration statement requirement, material information may not necessarily be available to investors.

We estimate that approximately 124 funds each file one new registration statement on Form N–14 annually, and that 68 funds each file one amendment to a registration statement on Form N–14 annually. Based on conversations with fund representatives, we estimate that the reporting burden is approximately 620 hours per respondent for a new Form N–14 registration statement and 300 hours per respondent for amending the Form N–14 registration statement. This time is spent, for example, preparing and reviewing the registration statements. Accordingly, we calculate the total estimated annual internal burden of responding to Form N–14 to be approximately 97,280 hours. In addition to the burden hours, based on conversations with fund representatives, we estimate that the total cost burden of compliance with the information collection requirements of Form N–14 is approximately $27,500 for preparing and filing an initial registration statement on Form N–14 and approximately $16,000 for preparing and filing an amendment to a registration statement on Form N–14. This includes, for example, the cost of goods and services purchased to prepare and update registration statements on Form N–14, such as for the services of outside counsel. Accordingly, we calculate the total estimated annual cost burden of responding to Form N–14 to be approximately $4,498,000.

Estimates of the average burden hours are made solely for the purposes of the Paperwork Reduction Act and are not derived from a comprehensive or even representative survey or study of the costs of Commission rules and forms. The collection of information under Form N–14 is mandatory. The information provided under Form N–14 will not be kept confidential. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

The public may view the background documentation for this information collection at the following Web site, *www.reginfo.gov.* Comments should be directed to: (i) Desk Officer for the Securities and Exchange Commission, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10102, New Executive Office Building, Washington, DC 20503, or by sending an email to: *Shagufta_Ahmed@omb.eop.gov;* and (ii) Pamela Dyson, Director/Chief Information Officer, Securities and Exchange Commission, c/o Remi Pavlik-Simon, 100 F Street NE., Washington, DC 20549 or send an email to: *PRA_Mailbox@sec.gov.* Comments must be submitted to OMB within 30 days of this notice.

Dated: March 1, 2016.

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05044 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77283; File No. SR-Phlx-2016–30]

Self-Regulatory Organizations; NASDAQ PHLX LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Pricing Schedule

March 3, 2016.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on February 26, 2016, NASDAQ PHLX LLC (''Phlx'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the Exchange's Pricing Schedule to update the Pricing Schedule in various ways, (1) remove unnecessary rule text and footnotes; (2) update names of Nasdaq exchanges to reflect a recent name change; (3) update the current definitions to add detail and rearrange rule text; and (4) rename the Payment for Order Flow Fee.

The text of the proposed rule change is available on the Exchange's Web site at *http://nasdaqomxphlx.cchwallstreet.com/,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to update its Pricing Schedule in various ways, which are explained below, to clarify its pricing. The Exchange proposes to specifically (1) remove unnecessary rule text and footnotes; (2) update names of the Exchange to reflect a recent name change; (3) update the current definitions to add detail and rearrange rule text; and (4) rename the Payment of Order Flow Fee.

Remove Unnecessary Rule Text and Footnotes

The Exchange proposes to remove unnecessary footnote numbers throughout the Pricing Schedule. The rule text contained within the footnotes will remain in the Pricing Schedule, the actual footnote numbers are being removed because the Exchange believes they are distracting and do not add clarity to the Pricing Schedule.

The Exchange also proposes to remove the references to SOX, HGX and OSX in Section II of the Pricing Schedule, titled ''Multiply Listed Options Fees,'' because these symbols are currently only listed on Phlx and there is no confusion that they are Singly Listed symbols. These symbols were previously listed on The NASDAQ Options Market, LLC for some time, but this is no longer the case. SOX, HGX and OSX will continue to be subject to Section III pricing. The Exchange is also removing references to XDM, XEH, XEV and XDV in Section III, titled ''Singly Listed Options,'' as the Exchange no longer lists options overlying these securities. These rule changes are non-substantive.

Name Changes

The Exchange's name was recently updated [3] from ''NASDAQ OMX PHLX LLC'' to ''NASDAQ PHLX LLC.'' The Exchange is amending its name in the Pricing Schedule along with references to ''NASDAQ OMX PSX,'' changing it to ''NASDAQ PSX,'' and NASDAQ OMX BX, Inc.'s name will be changed to NASDAQ BX, Inc.[4] The Exchange proposes to update these names within the Pricing Schedule. The Exchange proposes to remove all references to ''OMX'' within the Pricing Schedule. These rule changes are non-substantive.

Definitions

The Exchange proposes to relocate rule text currently located within the footnotes to the text of certain definitions so the Exchange may consolidate information. These rule changes are non-substantive.

Rename Payment for Order Flow as Marketing Fee

The Exchange is proposing to rename the ''Payment for Order Flow'' Fee or ''PFOF'' as the ''Marketing Fee.'' The Exchange believes that this reference to this fee is more appropriate. This rule change is non-substantive.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act [5] in general, and furthers the objectives of Section 6(b)(5) of the Act [6] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general to protect investors and the public interest, by bringing additional clarity to the Exchange's rules regarding pricing.

Remove Unnecessary Rule Text and Footnotes

The Exchange's proposal to remove unnecessary footnote numbers throughout the Pricing Schedule will bring clarity to the Pricing Schedule. The Exchange believes that removing the actual numbers, while retaining the rule text, will remove these distracting footnotes and make the Pricing Schedule easier to read. Also, the Exchange proposes to remove the references to SOX, HGX and OSX in Section II, titled ''Multiply Listed Options Fees,'' of the Pricing Schedule. This change is consistent with the Act and the protection of investors because these symbols are currently only listed on Phlx and there is no confusion that they are Singly Listed symbols. These symbols were listed on The NASDAQ Options Market, LLC for some time, but this is no longer the case. The Exchange's proposal to remove references to XDM, XEH, XEV and XDV in Section III, titled ''Singly Listed Options,'' is consistent with the Act because the Exchange no longer lists options overlying these securities and removing these references will bring clarity to the Pricing Schedule. The Exchange believes that these rule changes are consistent with the Act because they protect investors and the public interest by clarifying rules.

Name Changes

The Exchange's proposal to update the Exchange's name, the references to PSX and NASDAQ BX and remove all references to ''OMX'' will also clarify the Pricing Schedule by using the proper updated names. The Exchange believes that these rule changes are consistent with the Act because they protect investors and the public interest by clarifying its rules. These rule changes are non-substantive.

Definitions

The Exchange's proposal to relocate rule text within the footnotes will provide members with consolidated information in one place on the Pricing Schedule. The Exchange believes that these rule changes are consistent with the Act because they protect investors and the public interest by clarifying its rules. The Exchange is not altering the definitions; these changes are non-substantive.

Rename Payment for Order Flow as Marketing Fee

The Exchange's proposal to rename ''Payment for Order Flow'' Fee or ''PFOF'' as the ''Marketing Fee'' is consistent with the Act because this non-substantive change will not impact pricing and is simply a name change.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

Remove Unnecessary Rule Text and Footnotes

The Exchange's proposal to remove unnecessary footnotes throughout the Pricing Schedule, remove the references to SOX, HGX and OSX in Section II and remove references to XDM, XEH, XEV and XDV in Section III are non-substantive rule changes which will not impose an undue burden on competition.

Name Changes

The Exchange's proposal to update the Exchange's name, the references to PSX and NASDAQ BX and remove references to ''OMX'' are non-substantive rule changes which will not impose an undue burden on competition.

[3] *See* Securities Exchange Act Release No. 76654 (December 15, 2015), 80 FR 79396 (December 21, 2015) (SR–Phlx–2015–105).

[4] *See* Securities Exchange Act Release No. 76656 (December 15, 2015), 80 FR 79381 (December 21, 2015) (SR–BX–2015–080).

[5] 15 U.S.C. 78f(b).

[6] 15 U.S.C. 78f(b)(5).

Definitions

The Exchange's proposal to relocate rule text currently located within the footnotes will provide members with consolidated information in one place on the Pricing Schedule. The relocation of the rule text is a non-substantive rule change which will not impose an undue burden on competition.

Rename Payment for Order Flow as Marketing Fee

The Exchange's proposal to rename ''Payment for Order Flow'' or ''PFOF'' as ''Marketing Fee'' is a non-substantive rule change which will not impose an undue burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A)(iii) of the Act [7] and subparagraph (f)(6) of Rule 19b–4 thereunder.[8]

The Exchange has asked the Commission to waive the 30-day operative delay so that the proposal may become operative immediately upon filing. The Exchange has stated that it is requesting this waiver because the Exchange would like to update its Pricing Schedule immediately to reflect these non-substantive changes and avoid investor confusion. The Exchange believes that it is important to immediately update its Pricing Schedule to reflect current proposed rule changes to that document. Also, the Exchange believes that the amendments will bring clarity to the Pricing Schedule. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because this waiver will enable the Exchange to update its Pricing Schedule immediately with these non-substantive changes and thereby make the Pricing Schedule clearer for investors, avoiding potential points of confusion. For this reason, the Commission hereby waives the 30-day operative delay requirement and designates the proposed rule change as operative upon filing.[9]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is: (i) Necessary or appropriate in the public interest; (ii) for the protection of investors; or (iii) otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–Phlx–2016–30 on the subject line.

Paper Comments

- Send paper comments in triplicate to Brent J. Fields, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR-Phlx–2016–30. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR-Phlx–2016–30, and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[10]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05123 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[7] 15 U.S.C. 78s(b)(3)(a)(iii).

[8] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[9] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[10] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77277; File No. 4–657]

Joint Industry Plan; Notice of Filing and Immediate Effectiveness of Amendment to the Plan To Implement a Tick Size Pilot Program To Add National Stock Exchange, Inc. as a Participant

March 3, 2016.

Pursuant to Section 11A(a)(3) of the Securities Exchange Act of 1934 (''Exchange Act'') [1] and Rule 608 thereunder,[2] notice is hereby given that on February 5, 2016, National Stock Exchange, Inc. (''NSX'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') [3] an amendment to the Plan to Implement a Tick Size Pilot Program (''Plan'').[4] The amendment

[1] 15 U.S.C. 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] *See* letter from James G. Buckley, Chief Regulatory Officer, National Stock Exchange, Inc., to Brent J. Fields, Secretary, Securities and Exchange Commission, dated February 4, 2016.

[4] On May 6, 2015, the Commission issued an order approving the Plan, as modified by the Commission, to be implemented within one year after the date of publication of the Order for a two-year Pilot Period (the ''Approval Order''). *See* Securities Exchange Act Release No. 74892 (May 6, 2015), 80 FR 27513 (May 13, 2015). Thereafter, in November 2015, the Commission issued an order granting the Participants an exemption from implementing the Plan until October 3, 2016. *See*

adds NSX as a Participant [5] to the Plan. The Commission is publishing this notice to solicit comments on the amendment from interested persons.

I. Description and Purpose of the Plan Amendment

As noted above, the sole proposed amendment to the Plan is to add the Exchange as a Participant. At the time that the Plan was initially filed, NSX had ceased trading operations pursuant to a rule filing with the Commission; [6] however, even though it had ceased trading operations, NSX retained its status as a registered national securities exchange and self-regulatory organization. On December 5, 2015 [sic], the Commission issued an order approving a proposed rule change by NSX to enable trading activity to resume on the Exchange and make certain other rule changes.[7] As of December 31, 2015, NSX resumed its status as a fully operational national securities exchange, trading equity securities and equity derivative products on the basis of unlisted trading privileges.

Under Section II(C) of the Plan, any entity registered as a national securities exchange or national securities association under the Exchange Act may become a Participant by: (1) Executing a copy of the Plan, as then in effect; (2) providing each then-current Participant with a copy of such executed Plan; and (3) effecting an amendment to the Plan as specified in Section III(B) of the Plan. Section III(B) sets forth the process for a prospective new Participant to effect an amendment of the Plan. Specifically, the Plan provides that such an amendment to the Plan may be effected by the new national securities exchange or national securities association executing a copy of the Plan as then in effect (with the only changes being the addition of the new Participant's name in Section II(A) of the Plan); and submitting such executed Plan to the Commission for approval. The amendment will be effective when it is approved by the Commission in accordance with Rule 608 of Regulation NMS, or otherwise becomes effective pursuant to Rule 608 of Regulation NMS.

NSX has executed a copy of the Plan currently in effect, with the only change being the addition of its name in Section II(A) of the Plan, and has provided a copy of the Plan executed by NSX to each of the other Participants. Under the cover of this letter, NSX is submitting the executed Plan to the Commission for approval. Accordingly, all of the Plan requirements for effecting an amendment to the Plan to add NSX as a Participant have been satisfied.

II. Effectiveness of the Proposed Plan Amendment

The foregoing Plan amendment has become effective pursuant to Rule 608(b)(3)(iii) of the Exchange Act [8] because it involves solely technical or ministerial matters. At any time within sixty days of the filing of this amendment, the Commission may summarily abrogate the amendment and require that it be refiled pursuant to paragraph (b)(1) of Rule 608,[9] if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors or the maintenance of fair and orderly markets, to remove impediments to, and perfect the mechanisms of, a national market system or otherwise in furtherance of the purposes of the Act.

III. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the amendment is consistent with the Exchange Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number 4–657 on the subject line.

Paper Comments

- Send paper comments in triplicate to Brent J. Fields, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number 4–657. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the amendment between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal office of NSX. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number 4–657 and should be submitted on or before March 29, 2016.

By the Commission.

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05105 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

Securities Exchange Act Release No. 76382 (November 6, 2015), 80 FR 70284 (November 13, 2015).

[5] The term ''Participant'' is defined as a party to the Plan.

[6] *See* Securities Exchange Act Release No. 72107 (May 6, 2014), 79 FR 27017 (May 12, 2014) (SR–NSX–2014–14).

[7] *See* Securities Exchange Act Release No. 76640 (December 14, 2015), 80 FR 79122 (December 18, 2015) (SR–NSX–2015–05).

[8] 17 CFR 242.608(b)(3)(iii).

[9] 17 CFR 242.608(b)(1).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77281; File No. SR–NYSEArca–2016–37]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change Amending the Fees for NYSE Arca Proprietary Market Data as They Apply to Federal Agency Customers

March 3, 2016.

Pursuant to Section 19(b)(1)'' [1] of the Securities Exchange Act of 1934 (the ''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on February 26, 2016, NYSE Arca, Inc. (the ''Exchange'' or ''NYSE Arca'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the fees for NYSE Arca proprietary market data as they apply to Federal agency customers. The proposed rule change is available on the Exchange's Web site at *www.nyse.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the NYSE Arca Equities Proprietary Market Data Fee Schedule (''Fee Schedule''), to provide that market data fees do not apply to any Federal agency for their use of NYSE Arca real-time proprietary market data products. The term ''Federal agency'' as used in the Fee Schedule would include all Federal agencies subject to the Federal Acquisition Regulation (FAR),[4] as well as any Federal agency not subject to FAR that has promulgated its own procurement rules.[5]

The Exchange is proposing to specify that access fees, professional user fees and non-display fees do not apply to Federal agencies for those products to which those fees apply.[6] The proposal is designed to allow the Exchange to provide Federal agencies with NYSE Arca real-time proprietary market data products at no cost in support of Federal agencies' regulatory responsibilities. With the adoption of the proposed fee waiver, the Exchange is not waiving any of its contractual rights and all Federal agencies that subscribe to NYSE Arca real-time proprietary market data products will be required to execute the appropriate subscriber agreement, which includes, among other things, provisions against the redistribution of data.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[7] in general, and Sections 6(b)(4) and 6(b)(5) of the Act,[8] in particular, in that it provides an equitable allocation of reasonable fees among users and recipients of the data and is not designed to permit unfair discrimination among customers, issuers, and brokers.

The Exchange believes the proposal to eliminate the access fees, display fees for professional users, and non-display fees associated with its proprietary market data products for customers that are Federal agencies is reasonable, equitable and not unfairly discriminatory because it is designed to facilitate federal government regulation without giving an undue advantage to one set of commercial users over another. The Exchange believes that it is reasonable to assess no fees to Federal agencies that subscribe to the Exchange's proprietary market data products because Federal agencies do not use the Exchange's proprietary market data for commercial gain, but only for regulatory purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. In setting the proposed fees, the Exchange considered the competitiveness of the market for proprietary data and all of the implications of that competition. The Federal agencies that will benefit from the proposed rule change, however, do not use the Exchange's proprietary market data products for commercial purposes and do not compete with commercial users of the data. The Exchange believes that it has considered all relevant factors and has not considered irrelevant factors in order to establish fair, reasonable, and not unreasonably discriminatory fees and an equitable allocation of fees among all users.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A)[9] of the Act and subparagraph (f)(2) of Rule 19b–4[10] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B)[11] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–NYSEArca–2016–37 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

[4] FAR is the principal set of rules governing the process by which the U.S. federal government purchases goods and services.

[5] *See* 48 CFR 2.101. FAR defines ''Federal agency'' as ''any executive agency or any independent establishment in the legislative or judicial branch of the Government (except the Senate, the House of Representatives, the Architect of the Capitol, and any activities under the Architect's direction).'' ''Executive agency'' is defined as ''an executive department, a military department, or any independent establishment within the meaning of 5 U.S.C. 101, 102, and 104(1), respectively, and any wholly owned Government corporation within the meaning of 31 U.S.C. 9101.''

[6] These products are currently NYSE Arca Integrated Feed, NYSE ArcaBook, NYSE Arca BBO, NYSE Arca Trades and NYSE Arca Order Imbalances.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4), (5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

[11] 15 U.S.C. 78s(b)(2)(B).

All submissions should refer to File Number SR–NYSEArca–2016–37. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2016–37 and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05121 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Submission for OMB Review; Comment Request

Upon Written Request Copies Available From: Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE., Washington, DC 20549–2736.

Extension:

Rule 17g–4; SEC File No. 270–566, OMB Control No. 3235–0627.

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) (''PRA''), the Securities and Exchange Commission (''Commission'') has submitted to the Office of Management and Budget (''OMB'') a request for approval of extension of the previously approved collection of information provided for in Rule 17g–4 (17 CFR 240.17g–4) under the Securities Exchange Act of 1934 (15 U.S.C. 78a *et seq.*) (''Exchange Act'').

The Credit Rating Agency Reform Act of 2006 added a new section 15E, ''Registration of Nationally Recognized Statistical Rating Organizations,'' [1] to the Exchange Act. Pursuant to the authority granted under section 15E of the Exchange Act, the Commission adopted Rule 17g–4, which requires that a nationally recognized statistical rating organization (''NRSRO'') establish, maintain, and enforce written policies and procedures to prevent the misuse of material nonpublic information, including policies and procedures reasonably designed to prevent: (a) The inappropriate dissemination of material nonpublic information obtained in connection with the performance of credit rating services; (b) a person within the NRSRO from trading on material nonpublic information; and (c) the inappropriate dissemination of a pending credit rating action.[2]

There are 10 credit rating agencies registered with the Commission as NRSROs under section 15E of the Exchange Act, which have already established the policies and procedures required by Rule 17g–4. Based on staff experience, an NRSRO is estimated to spend an average of approximately 10 hours per year reviewing its policies and procedures regarding material nonpublic information and updating them (if necessary), resulting in an average industry-wide annual hour burden of approximately 100 hours.[3]

The Commission may not conduct or sponsor a collection of information unless it displays a currently valid OMB control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid OMB control number.

Background documentation for this information collection may be viewed at the following Web site: *www.reginfo.gov.* Comments should be directed to: (i) Desk Officer for the Securities and Exchange Commission, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10102, New Executive Office Building, Washington, DC 20503, or by sending an email to: *Shagufta_Ahmed@omb.eop.gov;* and (ii) Pamela Dyson, Director/Chief Information Officer, Securities and Exchange Commission, c/o Remi Pavlik-Simon, 100 F St. NE., Washington, DC 20549 or send an email to: *PRA_Mailbox@sec.gov.* Comments must be submitted to OMB within 30 days of this notice.

Dated: March 1, 2016.

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05042 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–32019; File No. 812–13754]

Apollo Investment Corporation, et al.; Notice of Application

March 2, 2016.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of application for an order under sections 17(d) and 57(i) of the Investment Company Act of 1940 (the ''Act'') and rule 17d–1 under the Act to permit certain joint transactions otherwise prohibited by sections 17(d) and 57(a)(4) of the Act and rule 17d–1 under the Act.

Summary of Application: Applicants request an order to permit certain business development companies and closed-end management investment companies to co-invest in portfolio companies with each other and with affiliated investment funds.

Applicants: Apollo Investment Corporation (''AIC''), Apollo Tactical Income Fund Inc. (''AIF''), Apollo Investment Management, L.P. (''AIM''), Apollo Management VII, L.P., Apollo Management VIII, L.P., Apollo Global Real Estate Management, L.P., Apollo Capital Management, L.P., Apollo SVF Management, L.P., Apollo Value Management, L.P., Apollo Europe Management, L.P., Apollo EPF Management, L.P., Apollo Credit Opportunity Management III LLC, Apollo Credit Management II, L.P., Apollo Credit Management (CLO), LLC, Apollo Credit Management II GP, LLC, Athene Asset Management, L.P., Apollo Credit Management, LLC (''ACM''), Apollo Palmetto Strategic Partnership, L.P., Apollo Special Opportunities Managed Account, L.P., Apollo Investment Europe II, L.P., Apollo Credit Opportunity Fund III LP, Apollo Investment Fund VII, L.P., Apollo Investment Fund VIII, L.P., Apollo

[12] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78o–7.

[2] *See* 17 CFR 240.17g–4; Release No. 34–55231 (Feb. 2, 2007), 72 FR 6378 (Feb. 9, 2007); Release No. 34–55857 (June 5, 2007), 72 FR 33564 (June 18, 2007).

[3] 10 currently registered NRSROs × 10 hours = 100 hours.

Commercial Real Estate Finance, Inc., ACREFI Management, LLC, Apollo Credit Senior Loan Fund, L.P., Apollo Senior Floating Rate Fund Inc. (''ASFRF''), ALM IV, Ltd., AGRE U.S. Real Estate Fund, L.P., ALM V, Ltd., Apollo Longevity, LLC, A–A European Senior Debt Fund, L.P., Apollo Management Singapore Pte. Ltd., Apollo European Strategic Management, L.P., Apollo European Strategic Investments (Holdings), L.P., Apollo Residential Mortgage, Inc., ARM Manager, LLC, AGRE Debt Fund I, L.P., AGRE–CRE Debt Manager, LLC, Apollo Natural Resources Partners, L.P., Apollo Commodities Management, L.P., Financial Credit Investment I, L.P., Financial Credit Investment I Manager, LLC, Apollo European Senior Debt Management, LLC, Apollo/Palmetto Short-Maturity Loan Portfolio, L.P., Apollo Credit Management (Senior Loans), LLC, 2011 Stone Tower HY Cayman Fund Trust, AGRE NA Management, LLC, ALM X, Ltd., ALM VI, Ltd., ALM VII, Ltd., ALM VII (R), LTD., ALM VII (R)–2, LTD., ALM VIII, Ltd., ALM IX, Ltd., ALM XI, Ltd., ALM XII, Ltd., ALM XIV, Ltd., Apollo AF Loan Trust 2012, Apollo Asia Private Credit Master Fund Pte., Ltd., Apollo Centre Street Management, LLC, Apollo Centre Street Partnership, L.P., Apollo Credit Management (Senior Loans) II, LLC, Apollo Credit Master Fund Ltd., Apollo Credit Strategies Master Fund Ltd., Apollo EPF II Partnership, Apollo EPF Management II, L.P., Apollo European Credit Management, L.P., Apollo European Credit Master Fund, L.P., Apollo SK Strategic Investments, L.P., Apollo SK Strategic Management, LLC, Apollo ST Debt Advisors LLC, Apollo ST Fund Management LLC, Apollo Structured Credit Recovery Master Fund II Ltd., Cornerstone CLO Ltd., Rampart CLO 2006–I Ltd., Rampart CLO 2007 Ltd., Stone Tower CLO V Ltd., Stone Tower CLO VI Ltd., Stone Tower CLO VII Ltd., Stone Tower Loan Trust 2010, Stone Tower Loan Trust 2011, Merx Aviation Finance, LLC (''Merx''), Athene Holding Ltd. (''Athene''), MidCap FinCo Holdings Limited (''MidCap''), ALME Loan Funding 2013–1 Limited, ALME Loan Funding II Limited, ALME Loan Funding IV B.V., ALME Loan Funding III Limited, Apollo Capital Spectrum Fund, L.P., Apollo Capital Spectrum Management, LLC, Apollo Credit Short Opportunities Master Fund, L.P., Apollo Credit Short Opportunities Management, LLC, Apollo Franklin Management, LLC, Apollo Franklin Partnership, L.P., Apollo Structured Credit Recovery Management III LLC, Apollo Structured Credit Recovery Master Fund III L.P., Apollo Total Return Management LLC, Apollo Total Return Master Fund L.P., Apollo Zeus Strategic Management, LLC, Apollo Zeus Strategic Investments, L.P., AP Investment Europe III, L.P., AESI II, L.P., Apollo Lincoln Fixed Income Fund, L.P., Apollo Lincoln Private Credit Fund, L.P., Apollo Emerging Markets Debt Master Fund LP, Apollo Emerging Markets Fixed Income Strategies Fund, L.P. Financial Credit Investment II, L.P., Financial Credit Investment II Manager, LLC, Apollo U.S. Real Estate Fund II, L.P., ALM XIX, Ltd., ALM XVI, Ltd., ALM XVII, Ltd., ALM XVIII, Ltd., Apollo A–N Credit Fund, L.P., Apollo A–N Credit Management, LLC, Apollo Hercules Management, LLC, Apollo Hercules Partners, L.P., Apollo Management International LLP, Apollo Moultrie Credit Fund Management, LLC, Apollo Moultrie Credit Fund, L.P., Apollo NA Management II, LLC, Apollo Tactical Value SPN Investments, L.P., Apollo Tactical Value SPN Management, LLC, Apollo Thunder Management, LLC, Apollo Thunder Partners, L.P., Apollo Total Return Enhanced Management, LLC, Apollo Total Return Master Fund Enhanced, L.P., Apollo Union Street Management, LLC, Apollo Union Street Partners, L.P., Financial Credit Investment III Manager, LLC, and Financial Credit Investment III, L.P.

Filing Dates: The application was filed on February 16, 2010, and amended on November 17, 2010, November 23, 2011, July 26, 2012, February 12, 2013, March 21, 2014, November 26, 2014 and March 1, 2016.

Hearing or Notification of Hearing: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on March 28, 2016, and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Pursuant to rule 0–5 under the Act, hearing requests should state the nature of the writer's interest, any facts bearing upon the desirability of a hearing on the matter, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, U.S. Securities and Exchange Commission, 100 F St. NE., Washington, DC 20549–1090. Applicants: 9 West 57th Street, New York, NY 10019.

FOR FURTHER INFORMATION CONTACT: David J. Marcinkus, Senior Counsel, or Dalia Blass, Assistant Chief Counsel, at (202) 551–6821 (Chief Counsel's Office, Division of Investment Management).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site by searching for the file number, or for an applicant using the Company name box, at *http://www.sec.gov/search/search.htm* or by calling (202) 551–8090.

Introduction

1. The Applicants request an order of the Commission under Sections 17(d) and 57(i) and Rule 17d–1 thereunder (the ''Order'') to permit, subject to the terms and conditions set forth in the application (the ''Conditions''), a Regulated Fund [1] and one or more other Regulated Funds and/or one or more Affiliated Funds [2] to enter into Co-Investment Transactions with each other. ''Co-Investment Transaction'' means any transaction in which a Regulated Fund (or its Wholly-Owned Investment Sub) participated together with one or more Affiliated Funds and/or one or more other Regulated Funds in reliance on the Order. ''Potential Co-Investment Transaction'' means any investment opportunity in which a Regulated Fund (or its Wholly-Owned Investment Sub) could not participate together with one or more Affiliated Funds and/or one or more other Regulated Funds without obtaining and relying on the Order.[3]

[1] ''Regulated Funds'' means AIC, ASFRF, AIF, the Future Regulated Funds and the BDC Downstream Funds (defined below). ''Future Regulated Fund'' means a closed-end management investment company (a) that is registered under the Act or has elected to be regulated as a BDC and (b) whose investment adviser is an Adviser.

''Adviser'' means AIM, ACM and the Existing Advisers to Affiliated Funds (identified in Appendix A to the application) together with any future investment adviser that (i) controls, is controlled by or is under common control with AGM, (ii) is registered as an investment adviser under the Advisers Act, and (iii) is not a Regulated Fund or a subsidiary of a Regulated Fund.

[2] ''Affiliated Fund'' means any Existing Affiliated Fund (identified in Appendix A to the application) or any entity (a) whose investment adviser is an Adviser, (b) that would be an investment company but for Section 3(c)(1), 3(c)(5)(C) or 3(c)(7) of the Act and (c) that is not a BDC Downstream Fund. Applicants represent that no Existing Affiliated Fund is a BDC Downstream Fund.

[3] All existing entities that currently intend to rely on the Order have been named as Applicants and any existing or future entities that may rely on the Order in the future will comply with its terms and Conditions set forth in the application.

Applicants

2. AIC is a closed-end management investment company incorporated in Maryland that has elected to be regulated as a business development company (''BDC'') under the Act.[4] AIC's Board [5] currently consists of eight members, six of whom are Independent Directors.[6] ASFRF and AIF are Maryland corporations that are registered as closed-end management investment companies. Each of ASFRF's and AIF's Board currently consists of six members, four of whom are Independent Directors.

3. AIM, a Delaware limited partnership that is registered under the Investment Advisers Act of 1940 (the ''Advisers Act''), serves as the investment adviser to AIC. ACM, a Delaware limited liability company that is registered as an investment adviser under the Advisers Act, serves as investment adviser to ASFRF and AIF.

4. Merx, a Delaware limited liability company, is a special purpose vehicle owned by AIC. AIM serves as Merx's investment adviser. Applicants state that Merx engages primarily in aircraft leasing and related businesses and is thus excluded from investment company status under Section 3(a). Merx is a BDC Downstream Fund.[7] If Applicants receive the requested Order, Merx may on occasion engage in Co-Investment Transactions with other Regulated Funds and with Affiliated Funds.[8]

5. The Existing Affiliated Funds are the investment funds identified in Appendix A to the application. Applicants represent that each Existing Affiliated Fund is a separate and distinct legal entity and each, other than Athene and MidCap, would be an investment company but for Section 3(c)(1), 3(c)(5)(C) or 3(c)(7) of the Act. Applicants state that Athene Holding does not come within the definition of investment company in Section 3(a)(1). As described in the application, Applicants state that Athene engages in the insurance business through wholly-owned subsidiary insurance companies which are excluded from investment company status by either Rule 3a–6 or Section 3(c)(3). Applicants state that Athene also invests through its controlled affiliate MidCap, which currently is excluded from investment company status by Section 3(b)(1), 3(c)(5) or 3(c)(6).[9] As with the other Affiliated Funds, each of Athene and MidCap is advised by an Adviser pursuant to a separate investment management agreement.

6. The Existing Advisers to Affiliated Funds, identified in Appendix A to the application, are the investment advisers to the Existing Affiliated Funds. Each of the Existing Advisers to Affiliated Funds is registered as an investment adviser under the Advisers Act.

7. Each of the Applicants may be deemed to be controlled by Apollo Global Management, LLC (''AGM''), a publicly traded company. AGM owns controlling interests in the Advisers and, thus, may be deemed to control the Regulated Funds and the Affiliated Funds. Applicants state that AGM is a holding company and does not currently offer investment advisory services to any person and is not expected to do so in the future. Applicants state that as a result, AGM has not been included as an Applicant.

8. Applicants state that a Regulated Fund may, from time to time, form one or more Wholly-Owned Investment Subs.[10] Such a subsidiary may be prohibited from investing in a Co-Investment Transaction with a Regulated Fund (other than its parent) or any Affiliated Fund because it would be a company controlled by its parent Regulated Entity for purposes of Section 57(a)(4) and Rule 17d–1. Applicants request that each Wholly-Owned Investment Sub be permitted to participate in Co-Investment Transactions in lieu of the Regulated Entity that owns it and that the Wholly-Owned Investment Sub's participation in any such transaction be treated, for purposes of the Order, as though the parent Regulated Fund were participating directly. Applicants represent that this treatment is justified because a Wholly-Owned Investment Sub would have no purpose other than serving as a holding vehicle for the Regulated Fund's investments and, therefore, no conflicts of interest could arise between the parent Regulated Fund and the Wholly-Owned Investment Sub. The Board of the parent Regulated Fund would make all relevant determinations under the Conditions with regard to a Wholly-Owned Investment Sub's participation in a Co-Investment Transaction, and the Board would be informed of, and take into consideration, any proposed use of a Wholly-Owned Investment Sub in the Regulated Fund's place. If the parent Regulated Fund proposes to participate in the same Co-Investment Transaction with any of its Wholly-Owned Investment Subs, the Board of the parent Regulated Fund will also be informed of, and take into consideration, the relative participation

[4] Section 2(a)(48) defines a BDC to be any closed-end investment company that operates for the purpose of making investments in securities described in Section 55(a)(1) through 55(a)(3) and makes available significant managerial assistance with respect to the issuers of such securities.

[5] ''Board'' means (i) with respect to a Regulated Fund other than a BDC Downstream Fund, the board of directors (or the equivalent) of the Regulated Fund and (ii) with respect to a BDC Downstream Fund, the Independent Party of the BDC Downstream Fund.

''Independent Party'' means, with respect to a BDC Downstream Fund, (i) if the BDC Downstream Fund has a board of directors (or the equivalent), the board or (ii) if the BDC Downstream Fund does not have a board of directors (or the equivalent), a transaction committee or advisory committee of the BDC Downstream Fund.

[6] ''Independent Director'' means a member of the Board of any relevant entity who is not an ''interested person'' as defined in Section 2(a)(19) of the Act. No Independent Director of a Regulated Fund (including any non-interested member of an Independent Party) will have a financial interest in any Co-Investment Transaction, other than indirectly through share ownership in one of the Regulated Funds.

[7] ''BDC Downstream Fund'' means either (a) with respect to AIC, Merx or (b) with respect to any Regulated Fund that is a BDC, an entity (i) that the BDC directly or indirectly controls, (ii) that is not controlled by any person other than the BDC (except a person that indirectly controls the entity solely because it controls the BDC), (iii) that would be an investment company but for section 3(c)(1) or 3(c)(7) of the Act, (iv) whose investment adviser is an Adviser and (v) that is not a Wholly-Owned Investment Sub.

[8] Applicants believe that allowing the other Regulated Funds and the Affiliated Funds to co-invest with Merx does not raise any legal or policy concerns that are not otherwise raised by allowing a Regulated Fund to co-invest with another Regulated Fund and/or one or more Affiliated Funds because, in terms of its operation and purpose, Merx differs from a private fund only in that it invests in and operates aircraft subject to leases instead of in investment securities.

[9] Applicants state that, although Athene and MidCap may not rely on section 3(c)(1), 3(c)(5)(c) or 3(c)(7) of the Act, as do the other Existing Affiliated Funds, Applicants do not believe that allowing Athene and MidCap to participate in Co-investment Transactions as Affiliated Funds raises any additional legal or policy concerns not otherwise raised by allowing a Regulated Fund to co-invest with one or more Affiliated Funds. Specifically, Applicants argue that Athene and MidCap are clients of Advisers the same way that an Affiliated Fund relying on Section 3(c)(1) or 3(c)(7) is a client of an Adviser. Although a relatively small portion of Athene's assets are managed by an investment adviser that is not an Adviser, only the portion of Athene's assets for which an Adviser has investment discretion will participate in Co-investment Transactions. Athene and MidCap may continue to be an Affiliated Fund in the future if it instead relies solely on Section 3(c)(1), 3(c)(5)(C) or 3(c)(7) and otherwise satisfies the criteria for an ''Affiliated Fund'' set out in the definition thereof.

[10] ''Wholly-Owned Investment Sub'' means an entity (i) that is wholly-owned by one of AIC, ASFRF, AIF or a Future Regulated Fund (with such Regulated Fund at all times holding, beneficially and of record, 100% of the voting and economic interests); (ii) whose sole business purpose is to hold one or more investments on behalf of such Regulated Fund; (iii) with respect to which such Regulated Fund's Board has the sole authority to make all determinations with respect to the entity's participation under the Conditions; and (iv) that would be an investment company but for Section 3(c)(1) or 3(c)(7) of the Act.

of the Regulated Fund and the Wholly-Owned Investment Sub.

Applicants' Representations

A. Allocation Process

9. Applicants state that the Advisers are presented with thousands of investment opportunities each year on behalf of their clients and must determine how to allocate those opportunities in a manner that, over time, is fair and equitable to all of their clients. Such investment opportunities may be Potential Co-Investment Transactions.

10. Applicants represent that they have established processes for allocating initial investment opportunities, opportunities for subsequent investments in an issuer and dispositions of securities holdings reasonably designed to treat all clients fairly and equitably. Further, Applicants represent that these processes will be extended and modified in a manner reasonably designed to ensure that the additional transactions permitted under the Order will both (i) be fair and equitable to the Regulated Funds and the Affiliated Funds and (ii) comply with the Conditions.

11. Specifically, applicants state that the Advisers are organized and managed such that the individual portfolio managers, as well as the teams and committees of portfolio managers, analysts and senior management (''Investment Teams'' and ''Investment Committees''), responsible for evaluating investment opportunities and making investment decisions on behalf of clients are promptly notified of the opportunities. If the requested Order is granted, the Advisers will establish, maintain and implement policies and procedures reasonably designed to ensure that, when such opportunities arise, the Advisers to the relevant Regulated Funds are promptly notified and receive the same information about the opportunity as any other Advisers considering the opportunity for their clients. In particular, consistent with Condition 1, if a Potential Co-Investment Transaction falls within the then-current Objectives and Strategies [11] and any Board-Established Criteria [12] of a Regulated Fund, the policies and procedures will require that the relevant portfolio managers, Investment Teams and Investment Committees responsible for that Regulated Fund receive sufficient information to allow the Regulated Fund's Adviser to make its independent determination and recommendations under the Conditions.

12. The Adviser to each applicable Regulated Fund will then make an independent determination of the appropriateness of the investment for the Regulated Fund in light of the Regulated Fund's then-current circumstances. If the Adviser to a Regulated Fund deems the Regulated Fund's participation in such Potential Co-Investment Transaction to be appropriate, then it will formulate a recommendation regarding the proposed order amount for the Regulated Fund.

13. Applicants state that, for each Regulated Fund and Affiliated Fund whose Adviser recommends participating in a Potential Co-Investment Transaction, the Adviser will submit a proposed order amount to the internal trading function, which is comprised of a group of individual traders who collect and execute trades. Applicants state further that each proposed order amount may be reviewed and adjusted, in accordance with the Advisers' written allocation policies and procedures, by an allocation committee for the area in question (*e.g.,* credit, private equity, real estate) on which senior management, legal and compliance personnel from that area participate or, in the case of issues involving multiple areas or AGM as a whole, an AGM-wide allocation committee on which senior management, legal and compliance personnel for AGM participate.[13] The order of a Regulated Fund or Affiliated Fund resulting from this process is referred to as its ''Internal Order''. The Internal Order will be submitted for approval by the Required Majority of any participating Regulated Funds in accordance with the Conditions.[14]

14. If the aggregate Internal Orders for a Potential Co-Investment Transaction do not exceed the size of the investment opportunity immediately prior to the submission of the orders to the underwriter, broker, dealer or issuer, as applicable (the ''External Submission''), then each Internal Order will be fulfilled as placed. If, on the other hand, the aggregate Internal Orders for a Potential Co-Investment Transaction exceed the size of the investment opportunity immediately prior to the External Submission, then the allocation of the opportunity will be made pro rata on the basis of the size of the Internal Orders.[15] If, subsequent to such External Submission, the size of the opportunity is increased or decreased, or if the terms of such opportunity, or the facts and circumstances applicable to the Regulated Funds' or the Affiliated Funds' consideration of the opportunity, change, the participants will be permitted to submit revised Internal Orders in accordance with written

[11] ''Objectives and Strategies'' means (i) with respect to any Regulated Fund other than a BDC Downstream Fund, its investment objectives and strategies, as described in its most current registration statement on Form N–2, other current filings with the Commission under the Securities Act of 1933 (the ''Securities Act'') or under the Securities Exchange Act of 1934, as amended, and its most current report to stockholders, and (ii) with respect to any BDC Downstream Fund, those investment objectives and strategies described in its disclosure documents (including private placement memoranda and reports to equity holders) and organizational documents (including operating agreements).

[12] ''Board-Established Criteria'' means criteria that the Board of a Regulated Fund may establish from time to time to describe the characteristics of Potential Co-Investment Transactions regarding which the Adviser to the Regulated Fund should be notified under Condition 1. The Board-Established Criteria will be consistent with the Regulated Fund's Objectives and Strategies. If no Board-Established Criteria are in effect, then the Regulated Fund's Adviser will be notified of all Potential Co-Investment Transactions that fall within the Regulated Fund's then-current Objectives and Strategies. Board-Established Criteria will be objective and testable, meaning that they will be based on observable information, such as industry/sector of the issuer, minimum EBITDA of the issuer, asset class of the investment opportunity or required commitment size, and not on characteristics that involve a discretionary assessment. The Adviser to the Regulated Fund may from time to time recommend criteria for the Board's consideration, but Board-Established Criteria will only become effective if approved by a majority of the Independent Directors. The Independent Directors of a Regulated Fund may at any time rescind, suspend or qualify its approval of any Board-Established Criteria, though Applicants anticipate that, under normal circumstances, the Board would not modify these criteria more often than quarterly.

[13] The reason for any such adjustment to a proposed order amount will be documented in writing and preserved in the records of the Advisers.

[14] ''Required Majority'' means a required majority, as defined in Section 57(o) of the Act. In the case of a Regulated Fund that is a registered closed-end fund, the Board members that make up the Required Majority will be determined as if the Regulated Fund were a BDC subject to Section 57(o). In the case of a BDC Downstream Fund with a board of directors (or the equivalent), the members that make up the Required Majority will be determined as if the BDC Downstream Fund were a BDC subject to Section 57(o). In the case of a BDC Downstream Fund with a transaction committee or advisory committee, the committee members that make up the Required Majority will be determined as if the BDC Downstream Fund were a BDC subject to Section 57(o) and as if the committee members were directors of the fund.

[15] The Advisers will maintain records of all proposed order amounts, Internal Orders and External Submissions in conjunction with Potential Co-Investment Transactions. Each applicable Adviser will provide the Eligible Directors with information concerning the Affiliated Funds' and Regulated Funds' order sizes to assist the Eligible Directors with their review of the applicable Regulated Fund's investments for compliance with the Conditions.

''Eligible Directors'' means, with respect to a Regulated Fund and a Potential Co-Investment Transaction, the members of the Regulated Fund's Board eligible to vote on that Potential Co-Investment Transaction under Section 57(o) of the Act.

allocation policies and procedures that the Advisers will establish, implement and maintain.[16]

B. Follow-On Investments

15. Applicants state that from time to time the Regulated Funds and Affiliated Funds may have opportunities to make Follow-On Investments [17] in an issuer in which a Regulated Fund and one or more other Regulated Funds and/or Affiliated Funds previously have invested.

16. Applicants propose that Follow-On Investments would be divided into two categories depending on whether the prior investment was a Co-Investment Transaction or a Pre-Boarding Investment.[18] If the Regulated Funds and Affiliated Funds had previously participated in a Co-Investment Transaction with respect to the issuer, then the terms and approval of the Follow-On Investment would be subject to the Standard Review Follow-Ons described in Condition 8. If the Regulated Funds and Affiliated Funds have not previously participated in a Co-Investment Transaction with respect to the issuer but hold a Pre-Boarding Investment, then the terms and approval of the Follow-On Investment would be subject to the Enhanced-Review Follow-Ons described in Condition 9. All Enhanced Review Follow-Ons require the approval of the Required Majority. For a given issuer, the participating Regulated Funds and Affiliated Funds would need to comply with the requirements of Enhanced-Review Follow-Ons only for the first Co-Investment Transaction. Subsequent Co-Investment Transactions with respect to the issuer would be governed by the requirements of Standard Review Follow-Ons.

17. A Regulated Fund would be permitted to invest in Standard Review Follow-Ons either with the approval of the Required Majority under Condition 8(c) or without Board approval under Condition 8(b) if it is (i) a Pro Rata Follow-On Investment [19] or (ii) a Non-Negotiated Follow-On Investment.[20] Applicants believe that these Pro Rata and Non-Negotiated Follow-On Investments do not present a significant opportunity for overreaching on the part of any Adviser and thus do not warrant the time or the attention of the Board. Pro Rata Follow-One Investments and Non-Negotiated Follow-On Investments remain subject to the Board's periodic review in accordance with Condition 10.

C. Dispositions

18. Applicants propose that Dispositions [21] would be divided into two categories. If the Regulated Funds and Affiliated Funds holding investments in the issuer had previously participated in a Co-Investment Transaction with respect to the issuer, then the terms and approval of the Disposition would be subject to the Standard Review Dispositions described in Condition 6. If the Regulated Funds and Affiliated Funds have not previously participated in a Co-Investment Transaction with respect to the issuer but hold a Pre-Boarding Investment, then the terms and approval of the Disposition would be subject to the Enhanced Review Dispositions described in Condition 7. Subsequent Dispositions with respect to the same issuer would be governed by Condition 6 under the Standard Review Dispositions.[22]

19. A Regulated Fund may participate in a Standard Review Disposition either with the approval of the Required Majority under Condition 6(d) or without Board approval under Condition 6(c) if (i) the Disposition is a Pro Rata Disposition [23] or (ii) the securities are Tradable Securities [24] and the Disposition meets the other requirements of Condition 6(c)(ii). Pro Rata Dispositions and Dispositions of a Tradable Security remain subject to the Board's periodic review in accordance with Condition 10.

D. Delayed Settlement

20. Applicants represent that under the terms and Conditions of the Application, all Regulated Funds and Affiliated Funds participating in a Co-

[16] However, if the size of the opportunity is decreased such that the aggregate of the original Internal Orders would exceed the amount of the remaining investment opportunity, then upon submitting any revised order amount to the Board of a Regulated Fund for approval, the Adviser to the Regulated Fund will also notify the Board promptly of the amount that the Regulated Fund would receive if the remaining investment opportunity were allocated pro rata on the basis of the size of the original Internal Orders. The Board of the Regulated Fund will then either approve or disapprove of the investment opportunity in accordance with condition 2, 6, 7, 8 or 9, as applicable.

[17] ''Follow-On Investment'' means an additional investment in the same issuer, including, but not limited to, through the exercise of warrants, conversion privileges or other rights to purchase securities of the issuer.

[18] ''Pre-Boarding Investments'' are investments in an issuer held by a Regulated Fund as well as one or more Affiliated Funds and/or one or more other Regulated Funds that: (i) were acquired prior to participating in any Co-Investment Transaction; (ii) were acquired in transactions in which the only term negotiated by or on behalf of such funds was price; and (iii) were acquired either: (A) in reliance on one of the JT No-Action Letters (defined below); or (B) in transactions occurring at least 90 days apart and without coordination between the Regulated Fund and any Affiliated Fund or other Regulated Fund.

[19] A ''Pro Rata Follow-On Investment'' is a Follow-On Investment (i) in which the participation of each Affiliated Fund and each Regulated Fund is proportionate to its outstanding investments in the issuer or security, as appropriate, immediately preceding the Follow-On Investment, and (ii) in the case of a Regulated Fund, a majority of the Board has approved the Regulated Fund's participation in the pro rata Follow-On Investments as being in the best interests of the Regulated Fund. The Regulated Fund's Board may refuse to approve, or at any time rescind, suspend or qualify, its approval of Pro Rata Follow-On Investments, in which case all subsequent Follow-On Investments will be submitted to the Regulated Fund's Eligible Directors in accordance with Condition 8(c).

[20] A ''Non-Negotiated Follow-On Investment'' is a Follow-On Investment in which a Regulated Fund participates together with one or more Affiliated Funds and/or one or more other Regulated Funds (i) in which the only term negotiated by or on behalf of the funds is price and (ii) with respect to which, if the transaction were considered on its own, the funds would be entitled to rely on one of the JT No-Action Letters.

''JT No-Action Letters'' means SMC Capital, Inc., SEC No-Action Letter (pub. avail. Sept. 5, 1995) and Massachusetts Mutual Life Insurance Company, SEC No-Action Letter (pub. avail. June 7, 2000).

[21] ''Disposition'' means the sale, exchange or other disposition of an interest in a security of an issuer.

[22] However, with respect to an issuer, if a Regulated Fund's first Co-Investment Transaction is an Enhanced Review Disposition, and the Regulated Fund does not dispose of its entire position in the Enhanced Review Disposition, then before such Regulated Fund may complete its first Standard Review Follow-On in such issuer, the Eligible Directors must review the proposed Follow-On Investment not only on a stand-alone basis but also in relation to the total economic exposure in such issuer (*i.e.,* in combination with the portion of the Pre-Boarding Investment not disposed of in the Enhanced Review Disposition), and the other terms of the investments. This additional review would be required because such findings would not have been required in connection with the prior Enhanced Review Disposition, but they would have been required had the first Co-Investment Transaction been an Enhanced Review Follow-On.

[23] A ''Pro Rata Disposition'' is a Disposition (i) in which the participation of each Affiliated Fund and each Regulated Fund is proportionate to its outstanding investment in the security subject to Disposition immediately preceding the Disposition; and (ii) in the case of a Regulated Fund, a majority of the Board has approved the Regulated Fund's participation in pro rata Dispositions as being in the best interests of the Regulated Fund. The Regulated Fund's Board may refuse to approve, or at any time rescind, suspend or qualify, its approval of Pro Rata Dispositions, in which case all subsequent Dispositions will be submitted to the Regulated Fund's Eligible Directors.

[24] ''Tradable Security'' means a security that meets the following criteria at the time of Disposition: (i) It trades on a national securities exchange or designated offshore securities market as defined in rule 902(b) under the Securities Act; (ii) it is not subject to restrictive agreements with the issuer or other security holders; and (iii) it trades with sufficient volume and liquidity (findings as to which are documented by the Advisers to any Regulated Funds holding investments in the issuer and retained for the life of the Regulated Fund) to allow each Regulated Fund to dispose of its entire position remaining after the proposed Disposition within a short period of time not exceeding 30 days at approximately the value (as defined by section 2(a)(41) of the Act) at which the Regulated Fund has valued the investment.

Investment Transaction will invest at the same time, for the same price and with the same terms, conditions, class, registration rights and any other rights, so that none of them receives terms more favorable than any other. However, the settlement date for an Affiliated Fund in a Co-Investment Transaction may occur up to ten business days after the settlement date for the Regulated Fund, and vice versa.[25] Nevertheless, in all cases, (i) the date on which the commitment of the Affiliated Funds and Regulated Funds is made will be the same even where the settlement date is not and (ii) the earliest settlement date and the latest settlement date of any Affiliated Fund or Regulated Fund participating in the transaction will occur within ten business days of each other.

E. Holders

21. Under Condition 15, if an Adviser, its principals, or any person controlling, controlled by, or under common control with the Adviser or its principals, and the Affiliated Funds (collectively, the ''Holders'') own in the aggregate more than 25 percent of the outstanding voting shares of a Regulated Fund (the ''Shares''), then the Holders will vote such Shares as directed by an independent third party when voting on matters specified in the Condition. Applicants believe that this Condition will ensure that the Independent Directors will act independently in evaluating Co-Investment Transactions, because the ability of the Adviser or its principals to influence the Independent Directors by a suggestion, explicit or implied, that the Independent Directors can be removed will be limited significantly. The Independent Directors shall evaluate and approve any independent party, taking into account its qualifications, reputation for independence, cost to the shareholders, and other factors that they deem relevant.

Applicants' Legal Analysis

1. Section 17(d) of the Act and rule 17d–1 under the Act prohibit participation by a registered investment company and an affiliated person in any ''joint enterprise or other joint arrangement or profit-sharing plan,'' as defined in the rule, without prior approval by the Commission by order upon application. Section 17(d) of the Act and rule 17d–1 under the Act are applicable to Regulated Funds that are registered closed-end investment companies.

2. Similarly, with regard to BDCs, section 57(a)(4) of the Act generally prohibits certain persons specified in section 57(b) from participating in joint transactions with the BDC or a company controlled by the BDC in contravention of rules as prescribed by the Commission. Section 57(i) of the Act provides that, until the Commission prescribes rules under section 57(a)(4), the Commission's rules under section 17(d) of the Act applicable to registered closed-end investment companies will be deemed to apply to transactions subject to section 57(a)(4). Because the Commission has not adopted any rules under section 57(a)(4), rule 17d–1 also applies to joint transactions with Regulated Funds that are BDCs.

3. Co-Investment Transactions are prohibited by either or both of Rule 17d–1 and Section 57(a)(4) without a prior exemptive order of the Commission to the extent that the Affiliated Funds and the Regulated Funds participating in such transactions fall within the category of persons described by Rule 17d–1 and/or Section 57(b), as applicable, vis-à-vis each participating Regulated Fund. Each of the participating Regulated Funds and Affiliated Funds may be deemed to be affiliated persons vis-à-vis a Regulated Fund within the meaning of section 2(a)(3) by reason of common control because (i) controlled affiliates of AGM manage each of the Affiliated Funds and ASFRF and AIF and may be deemed to control any future Regulated Fund, (ii) AGM controls AIM, which manages AIC, and (iii) AIC Downstream Funds, are, and, in the future will be, deemed to be controlled by AIM, AIC or certain of AIC's subsidiaries. Thus, each of the Affiliated Funds could be deemed to be a person related to the AIC Funds in a manner described by Section 57(b) and related to the other Regulated Funds in a manner described by Rule 17d–1; and therefore the prohibitions of Rule 17d–1 and Section 57(a)(4) would apply respectively to prohibit the Affiliated Funds from participating in Co-Investment Transactions with the Regulated Funds.

4. In passing upon applications under rule 17d–1, the Commission considers whether the company's participation in the joint transaction is consistent with the provisions, policies, and purposes of the Act and the extent to which such participation is on a basis different from or less advantageous than that of other participants.

5. Applicants state that in the absence of the requested relief, in many circumstances the Regulated Funds would be limited in their ability to participate in attractive and appropriate investment opportunities. Applicants state that, as required by Rule 17d–1(b), the Conditions ensure that the terms on which Co-Investment Transactions may be made will be consistent with the participation of the Regulated Funds being on a basis that it is neither different from nor less advantageous than other participants, thus protecting the equity holders of any participant from being disadvantaged. Applicants further state that the Conditions ensure that all Co-Investment Transactions are reasonable and fair to the Regulated Funds and their shareholders and do not involve overreaching by any person concerned, including the Advisers. Applicants state that the Regulated Funds' participation in the Co-Investment Transactions in accordance with the Conditions will be consistent with the provisions, policies, and purposes of the Act and would be done in a manner that is not different from, or less advantageous than, that of other participants.

Applicants' Conditions

Applicants agree that the Order will be subject to the following Conditions:

1. *Identification and Referral of Potential Co-Investment Transactions.*

(a) The Advisers will establish, maintain and implement policies and procedures reasonably designed to ensure that each Adviser is promptly notified of all Potential Co-Investment Transactions that fall within the then-current Objectives and Strategies and Board-Established Criteria of any Regulated Fund the Adviser manages.

(b) When an Adviser to a Regulated Fund is notified of a Potential Co-Investment Transaction under Condition 1(a), the Adviser will make an independent determination of the appropriateness of the investment for the Regulated Fund in light of the Regulated Fund's then-current circumstances.

2. *Board Approvals of Co-Investment Transactions.*

(a) If the Adviser deems a Regulated Fund's participation in any Potential Co-Investment Transaction to be appropriate for the Regulated Fund, it will then determine an appropriate level of investment for the Regulated Fund.

(b) If the aggregate amount recommended by the Advisers to be

[25] Applicants state this may occur for two reasons. First, when the Affiliated Fund or Regulated Fund is not yet fully funded because, when the Affiliated Fund or Regulated Fund desires to make an investment, it must call capital from its investors to obtain the financing to make the investment, and in these instances, the notice requirement to call capital could be as much as ten business days. Second, where, for tax or regulatory reasons, an Affiliated Fund or Regulated Fund does not purchase new issuances immediately upon issuance but only after a short seasoning period of up to ten business days.

invested in the Potential Co-Investment Transaction by the participating Regulated Funds and any participating Affiliated Funds, collectively, exceeds the amount of the investment opportunity, the investment opportunity will be allocated among them pro rata based on the size of the Internal Orders, as described in section III.A.1.b. of the application. Each Adviser to a participating Regulated Fund will promptly notify and provide the Eligible Directors with information concerning the Affiliated Funds' and Regulated Funds' order sizes to assist the Eligible Directors with their review of the applicable Regulated Fund's investments for compliance with these Conditions.

(c) After making the determinations required in Condition 1(b) above, each Adviser to a participating Regulated Fund will distribute written information concerning the Potential Co-Investment Transaction (including the amount proposed to be invested by each participating Regulated Fund and each participating Affiliated Fund) to the Eligible Directors of its participating Regulated Fund(s) for their consideration. A Regulated Fund will enter into a Co-Investment Transaction with one or more other Regulated Funds or Affiliated Funds only if, prior to the Regulated Fund's participation in the Potential Co-Investment Transaction, a Required Majority concludes that:

(i) The terms of the transaction, including the consideration to be paid, are reasonable and fair to the Regulated Fund and its equity holders and do not involve overreaching in respect of the Regulated Fund or its equity holders on the part of any person concerned;

(ii) the transaction is consistent with:

(A) The interests of the Regulated Fund's equity holders; and

(B) the Regulated Fund's then-current Objectives and Strategies;

(iii) the investment by any other Regulated Fund(s) or Affiliated Fund(s) would not disadvantage the Regulated Fund, and participation by the Regulated Fund would not be on a basis different from, or less advantageous than, that of any other Regulated Fund(s) or Affiliated Fund(s) participating in the transaction; provided that the Required Majority shall not be prohibited from reaching the conclusions required by this Condition 2(c)(iii) if:

(A) The settlement date for another Regulated Fund or an Affiliated Fund in a Co-Investment Transaction is later than the settlement date for the Regulated Fund by no more than ten business days or earlier than the settlement date for the Regulated Fund by no more than ten business days, in either case, so long as: (x) The date on which the commitment of the Affiliated Funds and Regulated Funds is made is the same; and (y) the earliest settlement date and the latest settlement date of any Affiliated Fund or Regulated Fund participating in the transaction will occur within ten business days of each other; or

(B) any other Regulated Fund or Affiliated Fund, but not the Regulated Fund itself, gains the right to nominate a director for election to a portfolio company's board of directors, the right to have a board observer or any similar right to participate in the governance or management of the portfolio company so long as: (x) The Eligible Directors will have the right to ratify the selection of such director or board observer, if any; (y) the Adviser agrees to, and does, provide periodic reports to the Regulated Fund's Board with respect to the actions of such director or the information received by such board observer or obtained through the exercise of any similar right to participate in the governance or management of the portfolio company; and (z) any fees or other compensation that any other Regulated Fund or Affiliated Fund or any affiliated person of any other Regulated Fund or Affiliated Fund receives in connection with the right of one or more Regulated Funds or Affiliated Funds to nominate a director or appoint a board observer or otherwise to participate in the governance or management of the portfolio company will be shared proportionately among any participating Affiliated Funds (who may, in turn, share their portion with their affiliated persons) and any participating Regulated Fund(s) in accordance with the amount of each such party's investment; and

(iv) the proposed investment by the Regulated Fund will not involve compensation, remuneration or a direct or indirect [26] financial benefit to the Advisers, any other Regulated Fund, the Affiliated Funds or any affiliated person of any of them (other than the parties to the Co-Investment Transaction), except (A) to the extent permitted by Condition 14, (B) to the extent permitted by Section 17(e) or 57(k), as applicable, (C) indirectly, as a result of an interest in the securities issued by one of the parties to the Co-Investment Transaction, or (D) in the case of fees or other compensation described in Condition 2(c)(iii)(B)(z).

3. *Right to Decline.* Each Regulated Fund has the right to decline to participate in any Potential Co-Investment Transaction or to invest less than the amount proposed.

4. *General Limitation.* Except for Follow-On Investments made in accordance with Conditions 8 and 9 below,[27] a Regulated Fund will not invest in reliance on the Order in any issuer in which a Related Party has an investment.[28]

5. *Same Terms and Conditions.* A Regulated Fund will not participate in any Potential Co-Investment Transaction unless (i) the terms, conditions, price, class of securities to be purchased, date on which the commitment is entered into and registration rights (if any) will be the same for each participating Regulated Fund and Affiliated Fund and (ii) the earliest settlement date and the latest settlement date of any participating Regulated Fund or Affiliated Fund will occur as close in time as practicable and in no event more than ten business days apart. The grant to one or more Regulated Funds or Affiliated Funds, but not the respective Regulated Fund, of the right to nominate a director for election to a portfolio company's board of directors, the right to have an observer on the board of directors or similar rights to participate in the governance or management of the portfolio company will not be interpreted so as to violate this Condition 5, if Condition 2(c)(iii)(B) is met.

6. *Standard Review Dispositions.*

(a) *General.* If any Regulated Fund or Affiliated Fund elects to sell, exchange or otherwise dispose of an interest in a security and one or more Regulated Funds and Affiliated Funds have previously participated in a Co-

[26] For example, procuring the Regulated Fund's investment in a Potential Co-Investment Transaction to permit an affiliate to complete or obtain better terms in a separate transaction would constitute an indirect financial benefit.

[27] This exception applies only to Follow-On Investments by a Regulated Fund in issuers in which that Regulated Fund already holds investments.

[28] ''Related Party'' means (i) any Close Affiliate and (ii) in respect of matters as to which any Adviser has knowledge, any Remote Affiliate.

''Close Affiliate'' means the Advisers, the Regulated Funds, the Affiliated Funds and any other person described in Section 57(b) (after giving effect to Rule 57b–1) in respect of any Regulated Fund (treating any registered investment company or series thereof as a BDC for this purpose) except for limited partners included solely by reason of the reference in Section 57(b) to Section 2(a)(3)(D).

''Remote Affiliate'' means any person described in Section 57(e) in respect of any Regulated Fund (treating any registered investment company or series thereof as a BDC for this purpose) and any limited partner holding 5% or more of the relevant limited partner interests that would be a Close Affiliate but for the exclusion in that definition.

Investment Transaction with respect to the issuer, then:

(i) The Adviser to such Regulated Fund or Affiliated Fund will notify each Regulated Fund that holds an investment in the issuer of the proposed Disposition at the earliest practical time; and

(ii) the Adviser to each Regulated Fund that holds an investment in the issuer will formulate a recommendation as to participation by such Regulated Fund in the Disposition.

(b) *Same Terms and Conditions.* Each Regulated Fund will have the right to participate in such Disposition on a proportionate basis, at the same price and on the same terms and conditions as those applicable to the Affiliated Funds and any other Regulated Fund.

(c) *No Board Approval Required.* A Regulated Fund may participate in such a Disposition without obtaining prior approval of the Required Majority if:

(i)(A) The participation of each Regulated Fund and Affiliated Fund in such Disposition is proportionate to its then-current holding of the security (or securities) of the issuer that is (or are) the subject of the Disposition; [29] (B) the Board of the Regulated Fund has approved as being in the best interests of the Regulated Fund the ability to participate in such Dispositions on a pro rata basis (as described in greater detail in the application); and (C) the Board of the Regulated Fund is provided on a quarterly basis with a list of all Dispositions made in accordance with this Condition; or

(ii) each security is a Tradable Security and (A) the Disposition is not to the issuer or any affiliated person of the issuer; and (B) the security is sold for cash in a transaction in which the only term negotiated by or on behalf of the participating Regulated Funds and Affiliated Funds is price.

(d) *Standard Board Approval.* In all other cases, the Adviser will provide its written recommendation as to the Regulated Fund's participation to the Eligible Directors and the Regulated Fund will participate in such Disposition solely to the extent that a Required Majority determines that it is in the Regulated Fund's best interests.

7. *Enhanced Review Dispositions.*

(a) *General.* If any Regulated Fund or Affiliated Fund elects to sell, exchange or otherwise dispose of a Pre-Boarding Investment in a Potential Co-Investment Transaction and the Regulated Funds and Affiliated Funds have not previously participated in a Co-Investment Transaction with respect to the issuer:

(i) The Adviser to such Regulated Fund or Affiliated Fund will notify each Regulated Fund that holds an investment in the issuer of the proposed Disposition at the earliest practical time;

(ii) the Adviser to each Regulated Fund that holds an investment in the issuer will formulate a recommendation as to participation by such Regulated Fund in the Disposition; and

(iii) the Advisers will provide to the Board of each Regulated Fund that holds an investment in the issuer all information relating to the existing investments in the issuer of the Regulated Funds and Affiliated Funds, including the terms of such investments and how they were made, that is necessary for the Required Majority to make the findings required by this Condition.

(b) *Enhanced Board Approval.* The Adviser will provide its written recommendation as to the Regulated Fund's participation to the Eligible Directors, and the Regulated Fund will participate in such Disposition solely to the extent that a Required Majority determines that:

(i) The Disposition complies with Conditions 2(c)(i), (ii), (iii)(A), and (iv);

(ii) the making and holding of the Pre-Boarding Investments were not prohibited by Section 57 or Rule 17d–1, as applicable, and records the basis for the finding in the Board minutes.

(c) *Additional Requirements.* The Disposition may only be completed in reliance on the Order if:

(i) *Same Terms and Conditions.* Each Regulated Fund has the right to participate in such Disposition on a proportionate basis, at the same price and on the same terms and conditions as those applicable to the Affiliated Funds and any other Regulated Fund;

(ii) *Original Investments.* All of the Affiliated Funds' and Regulated Funds' investments in the issuer are Pre-Boarding Investments;

(iii) *Advice of counsel.* Independent counsel to the Board advises that the making and holding of the investments in the Pre-Boarding Investments were not prohibited by Section 57 (as modified by Rule 57b–1) or Rule 17d–1, as applicable;

(iv) *Multiple Classes of Securities.* All Regulated Funds and Affiliated Funds that hold Pre-Boarding Investments in the issuer immediately before the time of completion of the Co-Investment Transaction hold the same security or securities of the issuer. For the purpose of determining whether the Regulated Funds and Affiliated Funds hold the same security or securities, they may disregard any security held by some but not all of them if, prior to relying on the Order, the Required Majority is presented with all information necessary to make a finding, and finds, that: (x) Any Regulated Fund's or Affiliated Fund's holding of a different class of securities (including for this purpose a security with a different maturity date) is immaterial [30] in amount, including immaterial relative to the size of the issuer; and (y) the Board records the basis for any such finding in its minutes. In addition, securities that differ only in respect of issuance date, currency, or denominations may be treated as the same security; and

(v) *No control.* The Affiliated Funds, the other Regulated Funds and their affiliated persons (within the meaning of Section 2(a)(3)(C) of the Act), individually or in the aggregate, do not control the issuer of the securities (within the meaning of Section 2(a)(9) of the Act).

8. *Standard Review Follow-Ons.*

(a) *General.* If any Regulated Fund or Affiliated Fund desires to make a Follow-On Investment in an issuer and the Regulated Funds and Affiliated Funds holding investments in the issuer previously participated in a Co-Investment Transaction with respect to the issuer:

(i) The Adviser to each such Regulated Fund or Affiliated Fund will notify each Regulated Fund that holds securities of the portfolio company of the proposed transaction at the earliest practical time; and

(ii) the Adviser to each Regulated Fund that holds an investment in the issuer will formulate a recommendation as to the proposed participation, including the amount of the proposed investment, by such Regulated Fund.

(b) *No Board Approval Required.* A Regulated Fund may participate in the Follow-On Investment without obtaining prior approval of the Required Majority if:

(i)(A) The proposed participation of each Regulated Fund and each Affiliated Fund in such investment is proportionate to its outstanding investments in the issuer or the security at issue, as appropriate,[31] immediately

[29] In the case of any Disposition, proportionality will be measured by each participating Regulated Fund's and Affiliated Fund's outstanding investment in the security in question immediately preceding the Disposition.

[30] In determining whether a holding is ''immaterial'' for purposes of the Order, the Required Majority will consider whether the nature and extent of the interest in the transaction or arrangement is sufficiently small that a reasonable person would not believe that the interest affected the determination of whether to enter into the transaction or arrangement or the terms of the transaction or arrangement.

[31] To the extent that a Follow-On Investment opportunity is in a security or arises in respect of a security held by the participating Regulated

preceding the Follow-On Investment; and (B) the Board of the Regulated Fund has approved as being in the best interests of the Regulated Fund the ability to participate in Follow-On Investments on a pro rata basis (as described in greater detail in the Application); or

(ii) it is a Non-Negotiated Follow-On Investment.

(c) *Standard Board Approval.* In all other cases, the Adviser will provide its written recommendation as to the Regulated Fund's participation to the Eligible Directors and the Regulated Fund will participate in such Follow-On Investment solely to the extent that a Required Majority makes the determinations set forth in Condition 2(c). If the only previous Co-Investment Transaction with respect to the issuer was an Enhanced Review Disposition the Eligible Directors must complete this review of the proposed Follow-On Investment both on a stand-alone basis and together with the Pre-Boarding Investments in relation to the total economic exposure and other terms of the investment.

(d) *Allocation.* If, with respect to any such Follow-On Investment:

(i) The amount of the opportunity proposed to be made available to any Regulated Fund is not based on the Regulated Funds' and the Affiliated Funds' outstanding investments in the issuer or the security at issue, as appropriate, immediately preceding the Follow-On Investment; and

(ii) the aggregate amount recommended by the Advisers to be invested in the Follow-On Investment by the participating Regulated Funds and any participating Affiliated Funds, collectively, exceeds the amount of the investment opportunity, then the Follow-On Investment opportunity will be allocated among them pro rata based on the size of the Internal Orders, as described in section III.A.1.b. of the application.

(e) *Other Conditions.* The acquisition of Follow-On Investments as permitted by this Condition will be considered a Co-Investment Transaction for all purposes and subject to the other Conditions set forth in the application.

9. *Enhanced Review Follow-Ons.*

(a) *General.* If any Regulated Fund or Affiliated Fund desires to make a Follow-On Investment in an issuer that is a Potential Co-Investment Transaction and the Regulated Funds and Affiliated Funds holding investments in the issuer have not previously participated in a Co-Investment Transaction with respect to the issuer:

(i) The Adviser to each such Regulated Fund or Affiliated Fund will notify each Regulated Fund that holds securities of the portfolio company of the proposed transaction at the earliest practical time;

(ii) the Adviser to each Regulated Fund that holds an investment in the issuer will formulate a recommendation as to the proposed participation, including the amount of the proposed investment, by such Regulated Fund; and

(iii) the Advisers will provide to the Board of each Regulated Fund that holds an investment in the issuer all information relating to the existing investments in the issuer of the Regulated Funds and Affiliated Funds, including the terms of such investments and how they were made, that is necessary for the Required Majority to make the findings required by this Condition.

(b) *Enhanced Board Approval.* The Adviser will provide its written recommendation as to the Regulated Fund's participation to the Eligible Directors, and the Regulated Fund will participate in such Follow-On Investment solely to the extent that a Required Majority reviews the proposed Follow-On Investment both on a stand-alone basis and together with the Pre-Boarding Investments in relation to the total economic exposure and other terms and makes the determinations set forth in Condition 2(c). In addition, the Follow-On Investment may only be completed in reliance on the Order if the Required Majority of each participating Regulated Fund determines that the making and holding of the Pre-Boarding Investments were not prohibited by Section 57 (as modified by Rule 57b–1) or Rule 17d–1, as applicable. The basis for the Board's findings will be recorded in its minutes.

(c) *Additional Requirements.* The Follow-On Investment may only be completed in reliance on the Order if:

(i) *Original Investments.* All of the Affiliated Funds' and Regulated Funds' investments in the issuer are Pre-Boarding Investments;

(ii) *Advice of counsel.* Independent counsel to the Board advises that the making and holding of the investments in the Pre-Boarding Investments were not prohibited by Section 57 (as modified by Rule 57b–1) or Rule 17d–1, as applicable;

(iii) *Multiple Classes of Securities.* All Regulated Funds and Affiliated Funds that hold Pre-Boarding Investments in the issuer immediately before the time of completion of the Co-Investment Transaction hold the same security or securities of the issuer. For the purpose of determining whether the Regulated Funds and Affiliated Funds hold the same security or securities, they may disregard any security held by some but not all of them if, prior to relying on the Order, the Required Majority is presented with all information necessary to make a finding, and finds, that: (x) Any Regulated Fund's or Affiliated Fund's holding of a different class of securities (including for this purpose a security with a different maturity date) is immaterial in amount, including immaterial relative to the size of the issuer; and (y) the Board records the basis for any such finding in its minutes. In addition, securities that differ only in respect of issuance date, currency, or denominations may be treated as the same security; and

(iv) *No control.* The Affiliated Funds, the other Regulated Funds and their affiliated persons (within the meaning of Section 2(a)(3)(C) of the Act), individually or in the aggregate, do not control the issuer of the securities (within the meaning of Section 2(a)(9) of the Act).

(d) *Allocation.* If, with respect to any such Follow-On Investment:

(i) The amount of the opportunity proposed to be made available to any Regulated Fund is not based on the Regulated Funds' and the Affiliated Funds' outstanding investments in the issuer or the security at issue, as appropriate, immediately preceding the Follow-On Investment; and

(ii) the aggregate amount recommended by the Advisers to be invested in the Follow-On Investment by the participating Regulated Funds and any participating Affiliated Funds, collectively, exceeds the amount of the investment opportunity, then the Follow-On Investment opportunity will be allocated among them pro rata based on the size of the Internal Orders, as described in section III.A.1.b. of the application.

(e) *Other Conditions.* The acquisition of Follow-On Investments as permitted by this Condition will be considered a Co-Investment Transaction for all

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Funds and Affiliated Funds, proportionality will be measured by each participating Regulated Fund's and Affiliated Fund's outstanding investment in the security in question immediately preceding the Follow-On Investment using the most recent available valuation thereof. To the extent that a Follow-On Investment opportunity relates to an opportunity to invest in a security that is not in respect of any security held by any of the participating Regulated Funds or Affiliated Funds, proportionality will be measured by each participating Regulated Fund's and Affiliated Fund's outstanding investment in the issuer immediately preceding the Follow-On Investment using the most recent available valuation thereof.

purposes and subject to the other Conditions set forth in the application.

10. *Board Reporting, Compliance and Annual Re-Approval.*

(a) Each Adviser to a Regulated Fund will present to the Board of each Regulated Fund, on a quarterly basis, and at such other times as the Board may request, (i) a record of all investments in Potential Co-Investment Transactions made by any of the other Regulated Funds or any of the Affiliated Funds during the preceding quarter that fell within the Regulated Fund's then-current Objectives and Strategies and Board-Established Criteria that were not made available to the Regulated Fund, and an explanation of why such investment opportunities were not made available to the Regulated Fund; (ii) a record of all Follow-On Investments in and Dispositions of investments in any issuer in which the Regulated Fund holds any investments by any Affiliated Fund or other Regulated Fund during the prior quarter; and (iii) all information concerning Potential Co-Investment Transactions and Co-Investment Transactions, including investments made by other Regulated Funds or Affiliated Funds that the Regulated Fund considered but declined to participate in, so that the Independent Directors, may determine whether all Potential Co-Investment Transactions and Co-Investment Transactions during the preceding quarter, including those investments that the Regulated Fund considered but declined to participate in, comply with the Conditions.

(b) All information presented to the Regulated Fund's Board pursuant to this Condition will be kept for the life of the Regulated Fund and at least two years thereafter, and will be subject to examination by the Commission and its staff.

(c) Each Regulated Fund's chief compliance officer, as defined in rule 38a–1(a)(4), will prepare an annual report for its Board each year that evaluates (and documents the basis of that evaluation) the Regulated Fund's compliance with the terms and Conditions of the application and the procedures established to achieve such compliance. In the case of a BDC Downstream Fund that does not have a chief compliance officer, the chief compliance officer of the BDC that controls the BDC Downstream Fund will prepare the report for the relevant Independent Party.

(d) The Independent Directors (including the non-interested members of each Independent Party) will consider at least annually whether continued participation in new and existing Co-Investment Transactions is in the Regulated Fund's best interests.

11. *Record Keeping.* Each Regulated Fund will maintain the records required by Section 57(f)(3) of the Act as if each of the Regulated Funds were a BDC and each of the investments permitted under these Conditions were approved by the Required Majority under Section 57(f).

12. *Director Independence.* No Independent Director (including the non-interested members of any Independent Party) of a Regulated Fund will also be a director, general partner, managing member or principal, or otherwise be an ''affiliated person'' (as defined in the Act) of any Affiliated Fund.

13. *Expenses.* The expenses, if any, associated with acquiring, holding or disposing of any securities acquired in a Co-Investment Transaction (including, without limitation, the expenses of the distribution of any such securities registered for sale under the Securities Act) will, to the extent not payable by the Advisers under their respective advisory agreements with the Regulated Funds and the Affiliated Funds, be shared by the Regulated Funds and the participating Affiliated Funds in proportion to the relative amounts of the securities held or being acquired or disposed of, as the case may be.

14. *Transaction Fees.*[32] Any transaction fee (including break-up, structuring, monitoring or commitment fees but excluding brokerage or underwriting compensation permitted by Section 17(e) or 57(k)) received in connection with any Co-Investment Transaction will be distributed to the participants on a pro rata basis based on the amounts they invested or committed, as the case may be, in such Co-Investment Transaction. If any transaction fee is to be held by an Adviser pending consummation of the transaction, the fee will be deposited into an account maintained by the Adviser at a bank or banks having the qualifications prescribed in Section 26(a)(1), and the account will earn a competitive rate of interest that will also be divided pro rata among the participants. None of the Advisers, the Affiliated Funds, the other Regulated Funds or any affiliated person of the Affiliated Funds or the Regulated Funds will receive any additional compensation or remuneration of any kind as a result of or in connection with a Co-Investment Transaction other than (i) in the case of the Regulated Funds and the Affiliated Funds, the pro rata transaction fees described above and fees or other compensation described in Condition 2(c)(iii)(B)(z), (ii) brokerage or underwriting compensation permitted by Section 17(e) or 57(k) or (iii) in the case of the Advisers, investment advisory compensation paid in accordance with investment advisory agreements between the applicable Regulated Fund(s) or Affiliated Fund(s) and its Adviser.

15. If the Holders own in the aggregate more than 25 percent of the Shares of a Regulated Fund, then the Holders will vote such Shares as directed by an independent third party (such as the trustee of a voting trust or a proxy adviser) when voting on (1) the election of directors; (2) the removal of one or more directors; or (3) any other matter under either the Act or applicable State law affecting the Board's composition, size or manner of election.

For the Commission, by the Division of Investment Management, under delegated authority.

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05043 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[32] Applicants are not requesting and the Commission is not providing any relief for transaction fees received in connection with any Co-Investment Transaction.

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–76955A; File No. SR–NYSEArca–2015–93]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Designation of a Longer Period for Commission Action on Proposed Rule Change, as Modified by Amendment No. 1, Relating to Listing and Trading of Shares of the Cumberland Municipal Bond ETF Under NYSE Arca Equities Rule 8.600; Correction

March 2, 2016.

AGENCY: Securities and Exchange Commission.

ACTION: Correction.

SUMMARY: The Securities and Exchange Commission published a document in the **Federal Register** on January 27, 2016 (81 FR 4724), concerning a Notice of Designation of a Longer Period for Commission Action on Proposed Rule Change, as Modified by Amendment No. 1, Relating to Listing and Trading of Shares of the Cumberland Municipal Bond ETF under NYSE Arca Equities Rule 8.600. The document contained a typographical error.

FOR FURTHER INFORMATION CONTACT: Kristie Diemer, Division of Trading and Markets, Securities and Exchange

Commission, 100 F Street NE., Washington, DC 20549, (202) 551–5613.

Correction

In the **Federal Register** of January 27, 2016, in FR Doc. 2016–01536, on page 4724, in the third line in the second column, correct the reference ''April 27, 2016'' to read ''March 11, 2016.''

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05045 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77284; File No. SR–BATS–2016–24]

Self-Regulatory Organizations; Bats BZX Exchange, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Rule 11.23, Auctions, To Lengthen the Auction Information Dissemination Periods for the Opening and Closing Auctions in BZX Listed Securities

March 3, 2016.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on February 25, 2016, Bats BZX Exchange, Inc. (the ''Exchange'' or ''BZX'') (f/k/a BATS Exchange, Inc.) filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Exchange has designated this proposal as a ''non-controversial'' proposed rule change pursuant to Section 19(b)(3)(A) of the Act[3] and Rule 19b–4(f)(6)(iii) thereunder,[4] which renders it effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of the Substance of the Proposed Rule Change

The Exchange filed a proposal to amend paragraphs (b)(2)(A) and (c)(2)(A) of Rule 11.23, Auctions, to lengthen the auction information dissemination periods for the Opening and Closing Auctions in BZX listed securities.[5]

The text of the proposed rule change is available at the Exchange's Web site at *www.batstrading.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend paragraphs (b)(2)(A) and (c)(2)(A) of Rule 11.23, Auctions, to lengthen the auction information dissemination periods for the Opening and Closing Auctions in BZX listed securities. In sum, Users[6] may begin to enter orders to participate in the Opening or Closing Auction at 8:00 a.m. Eastern Time, the beginning of the Pre-Opening Session.[7] Orders designated to participate in the Opening Auction will be queued until 9:30 a.m. Eastern Time, at which time they will be eligible to execute in the Opening Auction. Orders designated to participate in the Closing Auction will be queued until 4:00 p.m. Eastern Time, at which time they will be eligible to execute in the Closing Auction.

Currently, the Exchange begins to disseminate at 9:28 a.m. Eastern Time the Reference Price,[8] Indicative Price,[9] Auction Only Price,[10] and the lesser of Reference Buy Shares[11] and Reference Sell Shares[12] (collectively, the ''BZX Auction Information'') associated with the Opening Auction. The Exchange begins to disseminate the BZX Auction Information for the Closing Auction at 3:55 p.m. Eastern Time. For both the Opening and Closing Auction, the BZX Auction Information is updated and disseminated every five (5) seconds via electronic means to subscribers to the BZX Depth[13] and BZX Auction Feed[14] market data products and is also made available to other market participants by market data vendors. The BZX Auction Information is also made available on the Bats public Web site.

The Exchange now propose to lengthen the periods during which it disseminates BZX Auction Information for the Opening and Closing Auctions in BZX listed securities. As amended, Rule 11.23(b)(2)(A) would state that the Exchange will begin to disseminate BZX Auction Information for the Opening Auction at 8:00 a.m. Eastern Time, rather than 9:28 a.m. Eastern Time. Rule 11.23(c)(2)(A) would be amended to state that the Exchange will begin to disseminate BZX Auction Information for the Closing Auction at 3:00 p.m. Eastern Time, rather than 3:55 p.m. Eastern Time.[15]

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder that are applicable to a national securities exchange, and, in particular, with the requirements of Section 6(b) of the Act.[16] Specifically, the proposed change is consistent with Section 6(b)(5) of the Act,[17] because it is designed to promote just and equitable principles of trade, to remove impediments to, and perfect the mechanism of, a free and open market and a national market system, and, in general, to protect investors and the public interest. Specifically, the proposal supports the objectives of perfecting the mechanism of a free and open market and the national market system because lengthening the periods when which BZX Auction Information will be disseminated for the Opening and Closing Auctions will provide market participants with more information and time for them to evaluate the market for the security. The Exchange believes lengthening the dissemination period will enable greater participation in the Opening and Closing Auctions because it will provide periodic information about the ability of investors to execute orders at particular sizes and prices over a longer period of

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(6)(iii).

[5] A BZX listed security is a security listed on the Exchange pursuant to Chapter 14 of the Exchange's Rules and includes both corporate listed securities and Exchange Traded Products (''ETPs'').

[6] *See* Exchange Rule 1.5(cc).

[7] *See* Exchange Rule 11.23(b)(1)(A) and (c)(1)(A). The Pre-Opening Session is defined in Exchange Rule 1.5(r).

[8] *See* Exchange Rule 11.23(a)(19).

[9] *See* Exchange Rule 11.23(a)(10).

[10] *See* Exchange Rule 11.23(a)(2).

[11] *See* Exchange Rule 11.23(a)(18).

[12] *See* Exchange Rule 11.23(a)(21).

[13] *See* Exchange Rule 11.22(a) and (c).

[14] *See* Exchange Rule 11.22(i).

[15] The order entry cut off times for the Opening and Closing Auctions under Rules 11.23(b)((1)(A) and (c)(1)(A), respectively, will remain unchanged.

[16] 15 U.S.C. 78f(b).

[17] 15 U.S.C. 78f(b)(5).

time in advance of the auction. Finally, having greater knowledge about the trading interest in the BZX Book prior to the execution of the Opening and Closing Auctions will enable the market participants to make more informed decisions regarding their participation in the Opening or Closing Auctions. Therefore, the Exchange believes the proposed rule change promotes just and equitable principles of trade, removes impediments to, and perfects the mechanism of, a free and open market and a national market system.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the act. To the contrary, the proposal will promote competition because the Exchange believes lengthening the dissemination period will enable greater participation in the Opening and Closing Auctions by providing market participants with more information and time to evaluate the market for the security. The proposed rule change is, in effect, pro-competition as it promotes fair and orderly markets and protects investors, which, in turn, will buttress investor confidence and attract more investors to participate in the U.S. equities markets.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act [18] and Rule 19b–4(f)(6) [19] thereunder. Because the foregoing proposed rule does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest, provided that the self-regulatory organization has given the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change or such shorter time as designated by the Commission,[20] the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [21] and Rule 19b–4(f)(6) thereunder.[22]

Under Rule 19b–4(f)(6) of the Act,[23] a proposal does not become operative for 30 days after the date of its filing, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest. The Exchange has requested that the Commission waive the 30-day operative delay so that the proposal may become operative immediately upon filing. The Commission believes that waiver of the 30-day operative delay is consistent with the protection of investors and the public interest because market participants will be able to more immediately benefit from the extended period for dissemination of BZX Auction Information for the Opening and Closing Auctions. Accordingly, the Commission designates the proposal operative upon filing.[24]

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–BATS–2016–24 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–BATS–2016–24. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–BATS–2016–24, and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[25]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05124 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[18] 15 U.S.C. 78s(b)(3(A).

[19] 17 CFR 240.19b–4(f)(6).

[20] The Exchange has fulfilled this requirement.

[21] 15 U.S.C. 78s(b)(3)(A).

[22] 17 CFR 240.19b–4(f)(6).

[23] *Id.*

[24] For purposes only of waiving the operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[25] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77280; File No. SR–NYSE–2016–19]

Self-Regulatory Organizations; New York Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change Amending the Fees for NYSE Proprietary Market Data as They Apply to Federal Agency Customers

March 3, 2016.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on February 29, 2016, New York Stock Exchange LLC (''NYSE'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the fees for NYSE proprietary market data as they apply to Federal agency customers. The proposed rule change is available on the Exchange's Web site at *www.nyse.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the NYSE Proprietary Market Data Fee Schedule (''Fee Schedule''), to provide that market data fees do not apply to any Federal agency for their use of NYSE real-time proprietary market data products. The term ''Federal agency'' as used in the Fee Schedule would include all Federal agencies subject to the Federal Acquisition Regulation (FAR),[4] as well as any Federal agency not subject to FAR that has promulgated its own procurement rules.[5]

The Exchange is proposing to specify that access fees, professional user fees and non-display fees do not apply to Federal agencies for those products to which those fees apply.[6] The proposal is designed to allow the Exchange to provide Federal agencies with NYSE real-time proprietary market data products at no cost in support of Federal agencies' regulatory responsibilities. With the adoption of the proposed fee waiver, the Exchange is not waiving any of its contractual rights and all Federal agencies that subscribe to NYSE real-time proprietary market data products will be required to execute the appropriate subscriber agreement, which includes, among other things, provisions against the redistribution of data.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[7] in general, and Sections 6(b)(4) and 6(b)(5) of the Act,[8] in particular, in that it provides an equitable allocation of reasonable fees among users and recipients of the data and is not designed to permit unfair discrimination among customers, issuers, and brokers.

The Exchange believes the proposal to eliminate the access fees, display fees for professional users, and non-display fees associated with its proprietary market data products for customers that are Federal agencies is reasonable, equitable and not unfairly discriminatory because it is designed to facilitate federal government regulation without giving an undue advantage to one set of commercial users over another. The Exchange believes that it is reasonable to assess no fees to Federal agencies that subscribe to the Exchange's proprietary market data products because Federal agencies do not use the Exchange's proprietary market data for commercial gain, but only for regulatory purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. In setting the proposed fees, the Exchange considered the competitiveness of the market for proprietary data and all of the implications of that competition. The Federal agencies that will benefit from the proposed rule change, however, do not use the Exchange's proprietary market data products for commercial purposes and do not compete with commercial users of the data. The Exchange believes that it has considered all relevant factors and has not considered irrelevant factors in order to establish fair, reasonable, and not unreasonably discriminatory fees and an equitable allocation of fees among all users.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A) [9] of the Act and subparagraph (f)(2) of Rule 19b–4 [10] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

[1] 15 U.S.C.78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] FAR is the principal set of rules governing the process by which the U.S. federal government purchases goods and services.

[5] *See* 48 CFR 2.101. FAR defines ''Federal agency'' as ''any executive agency or any independent establishment in the legislative or judicial branch of the Government (except the Senate, the House of Representatives, the Architect of the Capitol, and any activities under the Architect's direction).'' ''Executive agency'' is defined as ''an executive department, a military department, or any independent establishment within the meaning of 5 U.S.C. 101, 102, and 104(1), respectively, and any wholly owned Government corporation within the meaning of 31 U.S.C. 9101.''

[6] These products are currently NYSE Integrated Feed, NYSE OpenBook, NYSE BBO, NYSE Trades, NYSE BQT, NYSE Order Imbalances, NYSE Alerts and NYSE Bonds.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4), (5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B) [11] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSE–2016–19 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSE–2016–19. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSE–2016–19 and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05120 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[11] 15 U.S.C. 78s(b)(2)(B).

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 32020; 813–00385]

Ares Management LLC; Notice of Application

March 2, 2016.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Notice of application for an order under sections 6(b) and 6(e) of the Investment Company Act of 1940 (the ''Act'') granting an exemption from all provisions of the Act and the rules and regulations thereunder, except sections 9, 17, 30, and 36 through 53 of the Act, and the rules and regulations thereunder (the ''Rules and Regulations''). With respect to sections 17(a), (d), (f), (g) and (j) and 30(a), (b), (e), and (h) of the Act, and the Rules and Regulations, and rule 38a–1 under the Act, the exemption is limited as set forth in the application.

SUMMARY: Summary of Application: Applicants request an order to exempt certain limited partnerships and other entities (''Partnerships'') formed for the benefit of eligible employees of Ares Management LLC (the ''Company'') and its affiliates from certain provisions of the Act. Each Partnership will be an ''employees' securities company'' within the meaning of section 2(a)(13) of the Act.

Applicant: The Company.

DATES: Filing Dates: The application was filed on May 11, 2015 and was amended on October 29, 2015 and January 15, 2016.

Hearing or Notification of Hearing: An order granting the application will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on March 28, 2016, and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, U.S. Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090; Applicant: 2000 Avenue of the Stars, 12th Floor, Los Angeles, CA 90067.

FOR FURTHER INFORMATION CONTACT: James D. McGinnis, Attorney-Advisor, at (202) 551–3025, or Sara Crovitz, Assistant Chief Counsel, at (202) 551–6720 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site by searching for the file number, or for an applicant using the Company name box, at *http://www.sec.gov/search/search.htm* or by calling (202) 551–8090.

Applicant's Representations

1. The Company is a Delaware limited liability company, and together with its ''affiliates,'' as defined in rule 12b–2 under the Securities Exchange Act of 1934 (the ''Exchange Act'') (collectively, ''Ares,'' and each, an ''Ares entity''), may organize certain partnerships, limited liability companies, business trusts or other entities (each a ''Partnership'' and, collectively, the ''Partnerships'') as ''employees' securities companies,'' as defined in section 2(a)(13) of the Act.

2. A Partnership may be organized under the laws of the state of Delaware, another state, or a jurisdiction outside the United States. A Partnership may be organized under the laws of a non-U.S. jurisdiction to address any tax, legal, accounting and regulatory considerations applicable to certain Eligible Employees (as defined below) in other jurisdictions or the nature of the program. Interests in a Partnership (''Interests'') may be issued in one or more series, each of which corresponds to particular Partnership investments (each, a ''Series''). Each Series will be an ''employees' securities company''

within the meaning of section 2(a)(13) of the Act. Each Partnership will operate as a closed-end management investment company, and a particular Partnership may operate as a ''diversified'' or ''non-diversified'' vehicle within the meaning of the Act. The Partnerships are intended to provide investment opportunities for Eligible Employees that are competitive with those at other investment management and financial services firms and to facilitate the recruitment and retention of high caliber professionals. Ares will control each Partnership within the meaning of section 2(a)(9) of the Act.

3. Each Partnership will have a general partner, managing member or other such similar entity (a ''General Partner''). All investors in a Partnership will be ''Limited Partners.'' The General Partner will be responsible for the overall management of each Partnership and will have the authority to make all decisions regarding the acquisition, management and disposition of Partnership investments. An Ares entity will be a General Partner of each Partnership. The General Partner may be permitted to delegate certain of its responsibilities regarding the acquisition, management and disposition of Partnership investments to an Investment Adviser (as defined below), provided that the ultimate responsibility for, and control of, each Partnership, remain with the General Partner.

4. The General Partner or another Ares entity will serve as investment adviser to a Partnership (the ''Investment Adviser''). The Investment Adviser will be registered as an investment adviser under the Investment Advisers Act of 1940 (the ''Advisers Act''), if required under applicable law. Each Investment Adviser shall comply with the standards prescribed in Sections 9, 36 and 37 of the Act. The Applicant represents and concedes that each General Partner and Investment Adviser managing a Partnership is an ''investment adviser'' within the meaning of Sections 9 and 36 of the Act and is subject to those sections. An Investment Adviser may be paid a management fee, which will generally be determined as a percentage of the capital commitments or assets under management (appreciated capital commitments) of the Limited Partners. A General Partner or Investment Adviser may receive a performance-based fee (a ''Carried Interest'') based on the net gains of the Partnership's investments in addition to any amount allocable to the General Partner's or Investment Adviser's capital contribution.[1]

5. If the General Partner determines that a Partnership enter into any side-by-side investment with an unaffiliated entity, the General Partner will be permitted to engage as sub-investment adviser the unaffiliated entity (an ''Unaffiliated Subadviser''), which will be responsible for the management of such side-by-side investment.

6. Interests in a Partnership will be offered without registration in reliance on section 4(a)(2) of the Securities Act of 1933 (the ''Securities Act''), or Regulation D or Regulation S under the Securities Act, and will be sold only to: (i) Eligible Employees; (ii) at the request of Eligible Employees and the discretion of the General Partner, to Qualified Participants (as defined below) of such Eligible Employees; or (iii) to Ares entities. Prior to offering Interests to an Eligible Employee or an Eligible Family Member (as defined below), a General Partner must reasonably believe that the Eligible Employee or Eligible Family Member will be capable of understanding and evaluating the merits and risks of participating in a Partnership and that each such individual is able to bear the economic risk of such participation and afford a complete loss of his or her investments in Partnerships. Investing in the Partnerships will be voluntary on the part of Eligible Employees and Qualified Participants.

7. To qualify as an ''Eligible Employee,'' (a) an individual must (i) be a current or former employee, officer or director or current Consultant[2] of Ares and (ii) except for certain individuals who meet the definition of ''knowledgeable employee'' in Rule 3c–5(a)(4) under the 1940 Act as if the Partnerships were ''Covered Companies'' within the meaning of the rule and a limited number of other employees of Ares[3] (collectively, ''*Non-Accredited Investors*''), meet the standards of an ''accredited investor'' under Rule 501(a)(5) or (a)(6) of Regulation D, or (b) an entity must (i) be a current Consultant of Ares and (ii) meet the standards of an ''accredited investor'' under Rule 501(a) of Regulation D. A Partnership may not have more than 35 Non-Accredited Investors. At the request of an Eligible Employee and the discretion of the General Partner, Interests may be assigned by such Eligible Employee, or sold directly by the Partnership, to a Qualified Participant of an Eligible Employee. In order to qualify as a ''Qualified Participant,'' an individual or entity must (i) be an Eligible Family Member or Eligible Investment Vehicle (in each case as defined below), respectively, of an Eligible Employee and (ii) if purchasing an Interest from a Partnership, except as discussed below, come within one of the categories of an ''accredited investor'' under Rule 501(a) of Regulation D. An ''Eligible Family Member'' is a spouse, parent, child, spouse of child, brother, sister or

[1] If a General Partner or Investment Adviser is registered under the Advisers Act, the Carried Interest payable to it by a Partnership will be pursuant to an arrangement that complies with rule 205–3 under the Advisers Act. If the General Partner or Investment Adviser is not required to register under the Advisers Act, the Carried Interest payable to it will comply with section 205(b)(3) of the Advisers Act (with such Partnership treated as though it were a business development company solely for the purpose of that section).

[2] A ''Consultant'' is a person or entity whom Ares has engaged on retainer to provide services and professional expertise on an ongoing basis as a regular consultant or as a business or legal adviser and who shares a community of interest with Ares and its employees. In order to participate in a Partnership, Consultants must be currently engaged with Ares and will be required to be sophisticated investors who qualify as accredited investors (''Accredited Investors'') under Rule 501(a)(5) or Rule 501(a)(6) of Regulation D under the Securities Act (if a Consultant is an individual) or, if not an individual, meet the standards of an ''accredited investor'' under Rule 501(a) of Regulation D. If a Consultant is an entity (such as, for example, a law firm or consulting firm), and the Consultant proposes to invest in the Partnership through a partnership, corporation or other entity that is controlled by the Consultant, the individual participants in such partnership, corporation or other entity will be limited to senior level employees, members or partners of the Consultant who are responsible for the activities of the Consultant and will be required to qualify as Accredited Investors. In addition, such entities will be limited to businesses controlled by individuals who have levels of expertise and sophistication in the area of investments in securities that are comparable to other Eligible Employees who are employees, officers or directors of Ares and who have an interest in maintaining an ongoing relationship with Ares. The individuals participating through such entities will belong to that class of persons who will have access to the directors and officers of the General Partner and/or the officers of Ares responsible for making investments for the Partnerships similar to the access afforded other Eligible Employees who are employees, officers or directors of Ares.

[3] Such employees must meet the sophistication requirements set forth in Rule 506(b)(2)(ii) of Regulation D under the Securities Act and may be permitted to invest his or her own funds in the Partnership if, at the time of the employee's investment in a Partnership, he or she (a) has a graduate degree in business, law or accounting, (b) has a minimum of five years of consulting, investment banking or similar business experience, and (c) has had reportable income from all sources of at least $100,000 in each of the two most recent years and a reasonable expectation of income from all sources of at least $140,000 in each year in which such person will be committed to make investments in a Partnership. In addition, such an employee will not be permitted to invest in any year more than 10% of his or her income from all sources for the immediately preceding year in the aggregate in such Partnership and in all other Partnerships in which he or she has previously invested.

grandchild of an Eligible Employee, including step and adoptive relationships. An ''Eligible Investment Vehicle'' is (a) a trust of which the trustee, grantor and/or beneficiary is an Eligible Employee, (b) a partnership, corporation or other entity controlled by an Eligible Employee,[4] or (c) a trust or other entity established solely for the benefit of an Eligible Employee and/or one or more Eligible Family Members of an Eligible Employee.

8. An Eligible Employee or Eligible Family Member may purchase an Interest through an Eligible Investment Vehicle only if either (i) the investment vehicle is an accredited investor, as defined in rule 501(a) of Regulation D under the Securities Act or (ii) the applicable Eligible Employee or Eligible Family Member is a settlor [5] and principal investment decision-maker with respect to the investment vehicle. Eligible Investment Vehicles that are not accredited investors will be included in accordance with Regulation D toward the 35 Non-Accredited Investor limit discussed above.

9. While the terms of a Partnership will be determined by Ares in its discretion, these terms will be fully disclosed to each Eligible Employee and, if a Qualified Participant of such Eligible Employee is required to make an investment decision with respect to whether or not to participate in a Partnership, to such Qualified Participant, at the time such Eligible Employee or Qualified Participant is invited to participate in the Partnership. A Partnership will send its Limited Partners an annual financial statement with respect to those Series in which the Limited Partner had an Interest within 120 days, or as soon as practicable, after the end of the Partnership's fiscal year. The financial statement will be audited [6] by independent certified public accountants, except in cases of Partnerships formed to make a single portfolio investment.[7] In addition, as soon as practicable after the end of each fiscal year of a Partnership, a report will be sent to each Limited Partner setting forth the information with respect such Limited Partner's share of income, gains, losses, credits, and other items for federal and state income tax purposes.

10. Interests in each Partnership will be non-transferable except with the prior written consent of the General Partner, and, in any event, no person or entity will be admitted into the Partnership as a Limited Partner unless such person is (i) an Eligible Employee, (ii) a Qualified Participant or (iii) an Ares entity. No sales load or similar fee of any kind will be charged in connection with the sale of Interests.

11. The Applicant states that a General Partner may have the right to repurchase or cancel the Interest of (i) an Eligible Employee who ceases to be an employee, officer, director or current Consultant of any Ares entity for any reason or (ii) any Qualified Participant of any person described in clause (i). Once a Consultant's ongoing relationship with an Ares entity is terminated: (i) Such Consultant and its Qualified Participants, if any, will not be permitted to contribute any additional capital to a Partnership; and (ii) the existing Interests of such Consultant and its Qualified Participants, if any, as of the date of such termination will (A) to the extent the governing documents of a Partnership provide for periodic redemptions in the ordinary course, be redeemed as of the next regularly scheduled redemption date and (B) to the extent the governing documents of a Partnership do not provide for such periodic redemptions (*e.g.,* as a result of the vehicle primarily investing in illiquid investments), be retained. The Partnership Agreement or private placement memorandum for each Partnership will describe, if applicable, the amount that a Limited Partner would receive upon repurchase, cancellation or forfeiture of its Interest. A Limited Partner would receive upon repurchase, cancellation or forfeiture of its Interest, at a minimum, the lesser of (i) the amount actually paid by or (subject to any vesting requirements) on behalf of the Limited Partner to acquire the Interest, plus interest, less any distributions, and (ii) the fair market value of the Interest determined at the time of the repurchase or cancellation as determined in good faith by the General Partner. The amount to be received by the Limited Partner will be subject to any applicable vesting schedule or forfeiture provisions and to the extent there is an oversubscription for a regularly scheduled redemption, existing Interests of the Limited Partner will be redeemed on a pro rata basis with all other Limited Partners who have made a request, in accordance with the governing documents, to be redeemed as of that redemption date and any subsequent regularly scheduled redemption date until all of such Limited Partner's existing Interests are redeemed.

12. The Applicant states that the Partnerships may invest either directly or through investments in limited partnerships and other investment pools (including pools that are exempt from registration in reliance on section 3(c)(1) or 3(c)(7) of the Act) and investments in registered investment companies.[8] Investments may be made side by side with Ares entities and through investment pools (including ''Aggregation Vehicles'') [9] sponsored or managed by an Ares entity or an unaffiliated entity.

13. The Applicant states that a Partnership may also co-invest in a portfolio company with Ares or an investment fund or separate account organized primarily for the benefit of investors who are not affiliated with Ares over which an Ares entity or an Unaffiliated Subadviser exercises investment discretion (''Third Party Funds''). The General Partner will not delegate management and investment discretion for the Partnership to an Unaffiliated Subadviser or a sponsor of a Third Party Fund. Side-by-side investments held by a Third Party Fund, or by an Ares entity in a transaction in which the Ares investment was made

[4] The inclusion of partnerships, corporations, or other entities controlled by an Eligible Employee in the definition of ''Eligible Investment Vehicle'' is intended to enable Eligible Employees to make investments in the Partnerships through personal investment vehicles for the purpose of personal and family investment and estate planning objectives.

[5] If such investment vehicle is an entity other than a trust, the term ''settlor'' will be read to mean a person who created such vehicle, alone or together with other Eligible Employees and/or Eligible Family Members, and contributed funds to such vehicle.

[6] ''Audit'' will have the meaning defined in rule 1–02(d) of Regulation S–X.

[7] In such cases, the Partnership may send unaudited financial statements, but each Limited Partner will receive financial statements of the single portfolio investment audited by such entity's independent accountants.

[8] The Applicant is not requesting any exemption from any provision of the Act or any rule thereunder that may govern the eligibility of a Partnership to invest in an entity relying on section 3(c)(1) or 3(c)(7) of the Act or any such entity's status under the Act.

[9] An ''Aggregation Vehicle'' is an investment pool sponsored or managed by an Ares entity that is formed solely for the purpose of permitting a Partnership and other Ares entities or Third Party Funds to collectively invest in other entities. The Applicant states that it may be more efficient for a Partnership and other Ares entities and Third Party Funds to invest in an entity together through an Aggregation Vehicle rather than having each investor separately acquire a direct interest in such entity. An Aggregation Vehicle will not be used to issue interests that discriminate against a Partnership or provide preferential treatment to an Ares entity or other Ares-related investors with respect to a portfolio company investment. The Applicant submits that because no investment decisions are made at the Aggregation Vehicle level, the fact that a person who participates in the Partnership's decision to acquire an interest in an Aggregation Vehicle also serves as an officer, director, general partner or investment adviser of the Aggregation Vehicle would not create a conflict of interest on the part of such person.

pursuant to a contractual obligation to a Third Party Fund, will not be subject to the restrictions contained in Condition 3 below. All other side-by-side investments held by Ares entities will be subject to the restrictions contained in Condition 3.

14. A Partnership will not borrow from any person if the borrowing would cause any person not named in section 2(a)(13) of the Act to own securities of the Partnership (other than short-term paper). A Partnership will not make any loans to the Company, its subsidiaries or any entity that controls the Company.[10] A Partnership will not borrow from any person if the borrowing would cause the Partnership not to be an ''employees' securities company'' as defined in Section 2(a)(13) of the Act. Any indebtedness of a Partnership, other than indebtedness incurred specifically on behalf of a Limited Partner where the Limited Partner has agreed to guarantee the loan or to act as co-obligor of the loan, will be the debt of the Partnership and without recourse to the Limited Partners.

15. In compliance with section 12(d)(1)(A)(i) of the Act, a Partnership will not purchase or otherwise acquire any security issued by a registered investment company if, immediately after the acquisition, the Partnership will own, in the aggregate, more than 3% of the outstanding voting stock of the registered investment company.

Applicant's Legal Analysis

1. Section 6(b) of the Act provides that, upon application, the Commission will exempt employees' securities companies from the provisions of the Act to the extent that the exemption is consistent with the protection of investors. Section 6(b) provides that the Commission will consider, in determining the provisions of the Act from which the company should be exempt, the company's form of organization and capital structure, the persons owning and controlling its securities, the price of the company's securities and the amount of any sales load, how the company's funds are invested, and the relationship between the company and the issuers of the securities in which it invests. Section 2(a)(13) defines an employees' securities company, in relevant part, as any investment company all of whose securities (other than short-term paper) are beneficially owned (a) by current or former employees, or persons on retainer, of one or more affiliated employers, (b) by immediate family members of such persons, or (c) by such employer or employers together with any of the persons in (a) or (b).

2. Section 7 of the Act generally prohibits investment companies that are not registered under section 8 of the Act from selling or redeeming their securities. Section 6(e) of the Act provides that, in connection with any order exempting an investment company from any provision of section 7, certain provisions of the Act, as specified by the Commission, will be applicable to the company and other persons dealing with the company as though the company were registered under the Act. The Applicant requests an order under sections 6(b) and 6(e) of the Act exempting the Partnerships from all provisions of the Act, except sections 9, 17, 30, and 36 through 53 of the Act, and the Rules and Regulations. With respect to sections 17(a), (d), (f), (g), and (j) and 30(a), (b), (e), and (h) of the Act, and the Rules and Regulations, and rule 38a–1 under the Act, the exemption is limited as set forth in the application.

3. Section 17(a) generally prohibits any affiliated person of a registered investment company, or any affiliated person of an affiliated person, acting as principal, from knowingly selling or purchasing any security or other property to or from the company. The Applicant requests an exemption from section 17(a) to the extent necessary to permit an Ares entity or a Third Party Fund (or any affiliated person of any such Ares entity or Third Party Fund), acting as principal, to purchase or sell securities or other property to or from any Partnership or any company controlled by such Partnership. Any such transaction to which any Partnership is a party will be effected only after a determination by the General Partner that the requirements of condition 1 below have been satisfied. In addition, the Applicant, on behalf of the Partnerships, represents that any transactions otherwise subject to section 17(a) of the Act, for which exemptive relief has not been requested, would require approval of the Commission.

4. The Applicant submits that an exemption from section 17(a) is consistent with the purposes of the Partnerships and the protection of investors. The Applicant states that the Limited Partners will be informed of the possible extent of the Partnership's dealings with Ares and of the potential conflicts of interest that may exist. The Applicant also states that, as professionals engaged in financial services businesses, the Limited Partners will be able to evaluate the risks associated with those dealings. The Applicant asserts that the community of interest among the Limited Partners and Ares will serve to reduce the risk of abuse. The Applicant acknowledges that the requested relief will not extend to any transactions between a Partnership and an Unaffiliated Subadviser or an affiliated person of an Unaffiliated Subadviser, or between a Partnership and any person who is not an employee, officer or director of Ares or is an entity outside of Ares and is an affiliated person of the Partnership as defined in section 2(a)(3)(E) of the Act (''Advisory Person'') or any affiliated person of such a person.

5. Section 17(d) of the Act and rule 17d–1 under the Act prohibit any affiliated person or principal underwriter of a registered investment company, or any affiliated person of such person or principal underwriter, acting as principal, from participating in any joint arrangement with the company unless authorized by the Commission. The Applicant requests relief to permit affiliated persons of the Partnerships, or affiliated persons of any of such persons, to participate in, or effect any transaction in connection with, any joint enterprise or other joint arrangement or profit-sharing plan in which a Partnership or a company controlled by a Partnership is a participant. The Applicant acknowledges that the requested relief will not extend to any transaction in which an Unaffiliated Subadviser or an Advisory Person, or an affiliated person of either such person, has an interest, except in connection with a Third Party Fund sponsored by an Unaffiliated Subadviser.

6. The Applicant asserts that compliance with section 17(d) would cause the Partnership to forego investment opportunities simply because a Limited Partner, the General Partner or any other affiliated person of the Partnership (or any affiliate of the affiliated person) made a similar investment. The Applicant submits that the types of investment opportunities considered by a Partnership often require each investor to make funds available in an amount that may be substantially greater than what a Partnership may be able to make available on its own. The Applicant contends that, as a result, the only way in which a Partnership may be able to participate in these opportunities may be to co-invest with other persons, including its affiliates. The Applicant asserts that the flexibility to structure co-investments and joint investments will not involve abuses of the type

[10] A Partnership may, subject to the terms and conditions set out herein, make investments in issuers that are portfolio companies of funds managed by Ares, and such investments may take the form of loans.

section 17(d) and rule 17d–1 were designed to prevent. In addition, the Applicant represents that any transactions otherwise subject to section 17(d) of the Act and rule 17d–1 thereunder, for which exemptive relief has not been requested, would require approval by the Commission.

7. Co-investments with Third Party Funds, or by an Ares entity pursuant to a contractual obligation to a Third Party Fund, will not be subject to condition 3 below. The Applicant notes that it is common for a Third Party Fund to require that Ares invest its own capital in Third Party Fund investments, and that Ares investments be subject to substantially the same terms as those applicable to the Third Party Fund. The Applicant believes it is important that the interests of the Third Party Fund take priority over the interests of the Partnerships, and that the Third Party Fund not be burdened or otherwise affected by activities of the Partnerships. In addition, the Applicant asserts that the relationship of a Partnership to a Third Party Fund is fundamentally different from a Partnership's relationship to Ares. The Applicant contends that the focus of, and the rationale for, the protections contained in the requested relief are to protect the Partnerships from any overreaching by Ares in the employer/employee context, whereas the same concerns are not present with respect to the Partnerships vis-à-vis a Third Party Fund.

8. Section 17(e) of the Act and rule 17e–1 under the Act limit the compensation an affiliated person may receive when acting as agent or broker for a registered investment company. The Applicant requests an exemption from section 17(e) to permit an Ares entity (including the General Partner) that acts as an agent or broker to receive placement fees, advisory fees, or other compensation from a Partnership in connection with the purchase or sale by the Partnership of securities, provided that the fees or other compensation are deemed ''usual and customary.'' The Applicant states that for purposes of the application, fees or other compensation that are charged or received by an Ares entity will be deemed ''usual and customary'' only if (a) the Partnership is purchasing or selling securities with other unaffiliated third parties, including Third Party Funds, (b) the fees or other compensation being charged to the Partnership (directly or indirectly) are also being charged to the unaffiliated third parties, including Third Party Funds, and (c) the amount of securities being purchased or sold by the Partnership (directly or indirectly) does not exceed 50% of the total amount of securities being purchased or sold by the Partnership (directly or indirectly) and the unaffiliated third parties, including Third Party Funds. The Applicant asserts that, because Ares does not wish to appear to be favoring the Partnerships, compliance with section 17(e) would prevent a Partnership from participating in transactions where the Partnership is being charged lower fees than unaffiliated third parties. The Applicant asserts that the fees or other compensation paid by a Partnership to an Ares entity will be the same as those negotiated at arm's length with unaffiliated third parties.

9. Rule 17e–1(b) under the Act requires that a majority of directors who are not ''interested persons'' (as defined in section 2(a)(19) of the Act) take actions and make approvals regarding commissions, fees, or other remuneration. Rule 17e–1(c) under the Act requires each investment company relying on the rule to satisfy the fund governance standards defined in rule 0–1(a)(7) under the Act (the ''Fund Governance Standards''). The Applicant requests an exemption from rule 17e–1 to the extent necessary to permit each Partnership to comply with the rule without having a majority of the directors of the General Partner who are not interested persons take actions and make determinations as set forth in paragraph (b) of the rule, and without having to satisfy the standards set forth in paragraph (c) of the rule. The Applicant states that because all the directors of the General Partner will be affiliated persons, without the relief requested, a Partnership could not comply with rule 17e–1. The Applicant states that each Partnership will comply with rule 17e–1 by having a majority of the directors of the General Partner take actions and make approvals as set forth in the rule. The Applicant states that each Partnership will otherwise comply with rule 17e–1.

10. Section 17(f) of the Act designates the entities that may act as investment company custodians, and rule 17f–1 under the Act imposes certain requirements when the custodian is a member of a national securities exchange. The Applicant requests an exemption from section 17(f) and subsections (a), (b) (to the extent such subsection refers to contractual requirements), (c), and (d) of rule 17f–1 to permit an Ares entity to act as custodian of Partnership assets without a written contract. The Applicant also requests an exemption from the rule 17f–1(b)(4) requirement that an independent accountant periodically verify the assets held by the custodian. The Applicant states that, because of the community of interest between Ares and the Partnerships and the existing requirement for an independent audit, compliance with this requirement would be unnecessary. The Applicant will comply with all other requirements of rule 17f–1.

11. The Applicant also requests an exemption from section 17 and rule 17f–2 to permit the following exceptions from the requirements of rule 17f–2: (a) A Partnership's investments may be kept in the locked files of the Ares, the General Partner or the Investment Adviser; (b) for purposes of paragraph (d) of the rule, (i) employees of the General Partner (or Ares) will be deemed to be employees of the Partnerships, (ii) officers or managers of the General Partner of a Partnership (or Ares) will be deemed to be officers of the Partnership and (iii) the General Partner of a Partnership or its board of directors will be deemed to be the board of directors of a Partnership and (c) in place of the verification procedure under paragraph (f) of the rule, verification will be effected quarterly by two employees, each of whom will have sufficient knowledge, sophistication and experience in business matters to perform such examination. The Applicant expects that, with respect to certain Partnerships, some of their investments may be evidenced only by partnership agreements, participation agreements or similar documents, rather than by negotiable certificates that could be misappropriated. The Applicant asserts that for such a Partnership, these instruments are most suitably kept in the files of Ares, the General Partner, or the Ares entity that serves as investment adviser to the Partnership, where they can be referred to as necessary. The Applicant will comply with all other provisions of rule 17f–2.

12. Section 17(g) of the Act and rule 17g–1 under the Act generally require the bonding of officers and employees of a registered investment company who have access to its securities or funds. Rule 17g–1 requires that a majority of directors who are not interested persons of a registered investment company take certain actions and give certain approvals relating to fidelity bonding. The rule also requires that the board of directors of an investment company relying on the rule satisfy the Fund Governance Standards. The Applicant requests relief to permit the General Partner's board of directors, who may be deemed interested persons, to take actions and make determinations as set forth in the rule. The Applicant states that, because all directors or other governing body of the General Partner

will be affiliated persons, a Partnership could not comply with rule 17g–1 without the requested relief. Specifically, each Partnership will comply with rule 17g–1 by having a majority of the General Partner's directors (or members of a comparable body) take actions and make determinations as set forth in rule 17g–1. The Applicant also requests an exemption from the requirements of: (i) Paragraph (g) of the rule relating to the filing of copies of fidelity bonds and related information with the Commission and the provision of notices to the board of directors; (ii) paragraph (h) of the rule relating to the appointment of a person to make the filings and provide the notices required by paragraph (g); and (iii) paragraph (j)(3) of the rule relating to compliance with the Fund Governance Standards. The Applicant states that the fidelity bond of each Partnership will cover Ares employees who have access to the securities and funds of the Partnership. The Applicant states that the Partnerships will comply with all other requirements of rule 17g–1.

13. Section 17(j) of the Act and paragraph (b) of rule 17j–1 under the Act make it unlawful for certain enumerated persons to engage in fraudulent or deceptive practices in connection with the purchase or sale of a security held or to be acquired by a registered investment company. Rule 17j–1 also requires that every registered investment company adopt a written code of ethics and that every access person of a registered investment company report personal securities transactions. The Applicant requests an exemption from section 17(j) and the provisions of rule 17j–1, except for the anti-fraud provisions of paragraph (b), because they assert that these requirements are unnecessarily burdensome as applied to the Partnerships. The relief requested will only extend to Ares entities and is not requested with respect to any Unaffiliated Subadviser or Advisory Person.

14. The Applicant requests an exemption from the requirements in sections 30(a), 30(b), and 30(e) of the Act, and the rules under those sections, that registered investment companies prepare and file with the Commission and mail to their shareholders certain periodic reports and financial statements. The Applicant contends that the forms prescribed by the Commission for periodic reports have little relevance to the Partnerships and would entail administrative and legal costs that outweigh any benefit to the Limited Partners. The Applicant requests exemptive relief to the extent necessary to permit each Partnership to report annually to its Limited Partners, as described in the application. The Applicant also requests an exemption from section 30(h) of the Act to the extent necessary to exempt the General Partner of each Partnership, members of the General Partner or any board of managers or directors or committee of Ares employees to whom the General Partner may delegate its functions, and any other persons who may be deemed to be members of an advisory board of a Partnership, from filing Forms 3, 4, and 5 under section 16(a) of the Exchange Act with respect to their ownership of Interests in the Partnership. The Applicant asserts that, because there will be no trading market and the transfers of Interests will be severely restricted, these filings are unnecessary for the protection of investors and burdensome to those required to make them.

15. Rule 38a–1 requires registered investment companies to adopt, implement and periodically review written policies reasonable designed to prevent violation of the federal securities law and to appoint a chief compliance officer. Each Partnership will comply will rule 38a–1(a), (c) and (d), except that (i) since the Partnership does not have a board of directors, the board of directors or other governing body of the General Partner will fulfill the responsibilities assigned to the Partnership's board of directors under the rule, and (ii) since the board of directors or other governing body of the General Partner does not have any disinterested members, (a) approval by a majority of the disinterested board members required by rule 38a–1 will not be obtained, and (b) the Partnerships will comply with the requirement in rule 38a–1(a)(4)(iv) that the chief compliance officer meet with the independent directors by having the chief compliance officer meet with the board of directors of the General Partner as constituted.

Applicant's Conditions

The Applicant agrees that any order granting the requested relief will be subject to the following conditions:

1. Each proposed transaction involving a Partnership otherwise prohibited by section 17(a) or section 17(d) of the Act and rule 17d–1 under the Act to which a Partnership is a party (the ''Section 17 Transactions'') will be effected only if the General Partner determines that (i) the terms of the Section 17 Transaction, including the consideration to be paid or received, are fair and reasonable to the Limited Partners of the Partnership and do not involve overreaching of the Partnership or its Limited Partners on the part of any person concerned, and (ii) the Section 17 Transaction is consistent with the interests of the Limited Partners, the Partnership's organizational documents and the Partnership's reports to its Limited Partners.[11]

In addition, the General Partner of a Partnership will record and preserve a description of all Section 17 Transactions, the General Partner's findings, the information or materials upon which the findings are based and the basis for the findings. All such records will be maintained for the life of the Partnership and at least six years thereafter and will be subject to examination by the Commission and its staff.[12]

2. The General Partner of each Partnership will adopt, and periodically review and update, procedures designed to ensure that reasonable inquiry is made, prior to the consummation of any Section 17 Transaction, with respect to the possible involvement in the transaction of any affiliated person or promoter of or principal underwriter for the Partnership or any affiliated person of such person, promoter or principal underwriter.

3. The General Partner of each Partnership will not invest the funds of the Partnership in any investment in which an ''Affiliated Co-Investor'' (as defined below) has acquired or proposes to acquire the same class of securities of the same issuer and where the investment transaction involves a joint enterprise or other joint arrangement within the meaning of Rule 17d–1 in which the Partnership and an Affiliated Co-Investor are participants (each such investment, a ''Rule 17d–1 Investment''), unless any such Affiliated Co-Investor, prior to disposing of all or part of its investment, (i) gives the General Partner sufficient, but not less than one day's, notice of its intent to dispose of its investment; and (ii) refrains from disposing of its investment unless the Partnership has the opportunity to dispose of the Partnership's investment prior to or concurrently with, on the same terms as, and pro rata with the Affiliated Co-

[11] If a Partnership invests through an Aggregation Vehicle and such investment is a Section 17 Transaction, this condition will apply with respect to both the investment in the Aggregation Vehicle and any investment by the Aggregation Vehicle of Partnership funds.

[12] Each Partnership will preserve the accounts, books and other documents required to be maintained in an easily accessible place for the first two years.

Investor.[13] The term ''Affiliated Co-Investor'' with respect to any Partnership means any person who is: (i) An ''affiliated person'' (as such term is defined in section 2(a)(3) of the Act) of the Partnership (other than a Third Party Fund); (ii) Ares; (iii) an officer or director of Ares; (iv) an Eligible Employee; or (v) an entity (other than a Third Party Fund) in which an Ares entity acts as a general partner or has a similar capacity to control the sale or other disposition of the entity's securities. The restrictions contained in this condition, however, shall not be deemed to limit or prevent the disposition of an investment by an Affiliated Co-Investor (i) to its direct or indirect wholly-owned subsidiary, to any company (a ''Parent'') of which the Affiliated Co-Investor is a direct or indirect wholly-owned subsidiary or to a direct or indirect wholly-owned subsidiary of its Parent, (ii) to immediate family members of the Affiliated Co-Investor or a trust or other investment vehicle established for any Affiliated Co-Investor or any such immediate family member, or (iii) when the investment is comprised of securities that are (a) listed on a national securities exchange registered under section 6 of the Exchange Act, (b) NMS stocks pursuant to section 11A(a)(2) of the Exchange Act and rule 600(a) of Regulation NMS thereunder, (c) government securities as defined in section 2(a)(16) of the Act or other securities that meet the definition of ''Eligible Security'' in rule 2a–7 under the Act, or (d) listed or traded on any foreign securities exchange or board of trade that satisfies regulatory requirements under the law of the jurisdiction in which such foreign securities exchange or board of trade is organized similar to those that apply to a national securities exchange or a national market system for securities.

4. Each Partnership and its General Partner will maintain and preserve, for the life of each Series of the Partnership and at least six years thereafter, such accounts, books and other documents constituting the record forming the basis for the audited financial statements that are to be provided to the Limited Partners in the Partnership, and each annual report of the Partnership required to be sent to the Limited Partners, and agree that all such records will be subject to examination by the Commission and its staff.[14]

5. Within 120 days after the end of each fiscal year of each Partnership, or as soon as practicable thereafter, the General Partner of each Partnership will send to each Limited Partner having an Interest in the Partnership at any time during the fiscal year then ended, Partnership financial statements audited by the Partnership's independent accountants with respect to those Series in which the Limited Partner had an Interest, except under certain circumstances in the case of a Partnership formed to make a single portfolio investment. In such cases, the Partnership may send unaudited financial statements, but each Limited Partner will receive financial statements of the single portfolio investment audited by such entity's independent accountants. At the end of each fiscal year, the General Partner will make or cause to be made a valuation of all of the assets of the Partnership as of such fiscal year end in a manner consistent with customary practice with respect to the valuation of assets of the kind held by the Partnership. In addition, within 120 days after the end of each fiscal year of each Partnership (or as soon as practicable thereafter), the General Partner will send a report to each person who was a Limited Partner at any time during the fiscal year then ended, setting forth such tax information as shall be necessary for the preparation by the Limited Partner of that partner's federal and state income tax returns and a report of the investment activities of the Partnership during that fiscal year.

6. If a Partnership makes purchases or sales from or to an entity affiliated with the Partnership by reason of an officer, director or employee of an Ares entity (i) serving as an officer, director, general partner, manager or investment adviser of the entity (other than an entity that is an Aggregation Vehicle), or (ii) having a 5% or more investment in the entity, such individual will not participate in the Partnership's determination of whether or not to effect the purchase or sale.

For the Commission, by the Division of Investment Management, under delegated authority.

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05039 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[13] If a Partnership invests in a Rule 17d–1 Investment through an Aggregation Vehicle, the requirements of clauses (i) and (ii) of this sentence shall apply to both the Affiliated Co-Investor's disposition of such Rule 17d–1 Investment and, if the Affiliated Co-Investor also holds a Rule 17d–1 Investment through such Aggregation Vehicle, its disposition of all or part of its investment in the Aggregation Vehicle.

[14] Each Partnership will preserve the accounts, books and other documents required to be maintained in an easily accessible place for the first two years.

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77282; File No. SR–BX–2016–013]

Self-Regulatory Organizations; NASDAQ OMX BX, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change to Amend Access Services Fees under Rule 7015

March 3, 2016.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on February 23, 2016, NASDAQ OMX BX, Inc. (''Exchange'')[3] filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the Exchange's Access Services fees under Rule 7015 to: (i) Assess a $25/port/month Disaster Recovery Port fee for Disaster Recovery Ports used with FIX Trading Ports, OUCH, RASH, and DROP ports; and (ii) assess a $100/port/month fee for Trading Ports used in Test Mode.

The text of the proposed rule change is available on the Exchange's Web site at *http://nasdaqomxbx.cchwallstreet.com/,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] In the filing, the Exchange states that it has legally changed its name to NASDAQ BX, Inc. with the state of Delaware, and that the Exchange is in the process of both amending its Form 1 with the Commission and changing its rules to reflect this new name.

the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change to Rule 7015 is to amend the Exchange's Access Services fees under Rule 7015 to: (i) Assess a $25/port/month Disaster Recovery Port fee for Disaster Recovery Ports used with FIX Trading Ports, OUCH, RASH, and DROP ports; and (ii) assess a $100/port/month fee for Trading Ports used in Test Mode.

First Change

The Exchange is in the process of transitioning its Disaster Recovery (''DR'') functionality for the U.S. equities and options markets from Ashburn, VA to its new Chicago, IL data center. The Exchange has invested and installed new equipment in the Chicago data center for client connectivity and for the infrastructure of Exchange systems. The Exchange chose Chicago as the location of its new DR data center as many other exchanges are using this same location for a disaster recovery or a primary location and, as a result, many of our market participants have a presence or connection at this location, thus making it easier and less expensive for many market participants to connect to the Exchange for DR.

Under Rule 7015, member firms may subscribe to DR ports, which provide backup connectivity in the event of a failure or disaster rendering their primary connectivity at Carteret, NJ subscribed to under Rule 7015 unavailable. To date, the Exchange has transitioned its FIX Trading Ports, OUCH, RASH, and DROP Ports to the Chicago center from Ashburn. Currently, the Exchange does not assess a fee for any DR ports.

The Exchange has incurred an initial cost associated with moving DR ports to the Chicago center, including the purchase of upgraded hardware and physical space to house the DR ports, which is more expensive than the Ashburn location. The Exchange also incurs ongoing costs in maintaining the DR ports, including costs incurred maintaining servers and their physical location, monitoring order activity, and other support, which is collectively more expensive in Chicago than Ashburn. Accordingly, the Exchange is proposing to assess a fee of $25 per port, per month for DR Ports used with FIX Trading Ports, OUCH, RASH, and DROP Ports.

Second Change

Under Rule 7015, Member firms may subscribe to Trading Ports used in Test Mode, which are trading ports available in primary market location in Carteret, NJ, that are exclusively used for testing purposes, at no cost. These ports may not be used for trading in securities in the System, but rather allow a member firm to test their systems prior to connecting to the live trading environment. Test Ports are identical to trading ports [4] and share the same infrastructure, but are restricted to only allow order entry into the System in test symbols. A member firm may elect to designate a subscribed trading port as either in ''production mode'' or in ''test mode.'' A Trading Port that is in production mode allows a member firm to send orders for execution on the Exchange system in the normal course. When a member firm changes a trading port's status to test mode, the Exchange will not allow normal order activity to occur through the port but rather it limits all order activity to test symbols. Under Rule 7015, member firms are assessed a monthly fee of $500 per port for each trading port subscribed in production mode. Member firms are not currently assessed a fee for Trading Ports used in Test Mode.

The Exchange has audited the use of Trading Ports used in Test Mode and found that a majority of Trading Ports used in Test Mode are not used for testing, but rather remain idle. The Exchange incurs costs associated with maintaining such ports, including costs incurred maintaining servers and their physical location, monitoring order activity, and other support. Accordingly, the Exchange is proposing to assess a fee of $100 per port, per month.[5]

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act [6] in general, and furthers the objectives of Sections 6(b)(4) and 6(b)(5) of the Act [7] in particular, in that it provides for the equitable allocation of reasonable dues, fees and other charges among members and issuers and other persons using any facility or system which the Exchange operates or controls, and is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

The Commission and the courts have repeatedly expressed their preference for competition over regulatory intervention in determining prices, products, and services in the securities markets. In Regulation NMS, while adopting a series of steps to improve the current market model, the Commission highlighted the importance of market forces in determining prices and SRO revenues and, also, recognized that current regulation of the market system ''has been remarkably successful in promoting market competition in its broader forms that are most important to investors and listed companies.'' [8] Likewise, in *NetCoalition* v. *Securities and Exchange Commission* [9] (''NetCoalition'') the DC Circuit upheld the Commission's use of a market-based approach in evaluating the fairness of market data fees against a challenge claiming that Congress mandated a cost-based approach.[10] As the court emphasized, the Commission ''intended in Regulation NMS that 'market forces, rather than regulatory requirements' play a role in determining the market data . . . to be made available to investors and at what cost.'' [11]

Further, ''[n]o one disputes that competition for order flow is 'fierce.' . . . As the SEC explained, '[i]n the U.S. national market system, buyers and sellers of securities, and the broker-dealers that act as their order-routing agents, have a wide range of choices of where to route orders for execution'; [and] 'no exchange can afford to take its market share percentages for granted' because 'no exchange possesses a monopoly, regulatory or otherwise, in the execution of order flow from broker dealers'. . . .'' [12]

[4] E.g., FIX, RASH, and OUCH.

[5] The Exchange bills Access Services subscriptions by prorating the first monthly fee by the number of days that subscription was subscribed and thereafter assesses the full monthly fee, including the full month in which the subscription is cancelled. If a subscriber elects to change a test mode port to a production port in a given month, the Exchange will assess the Trading Ports used in Test Mode fee, which may be prorated if subscribed to in the same month, and will also assess the production port fee, which will be prorated from the date the change is made through the end of the month. Likewise, if a subscriber elects to change a production mode port to a test mode port in a given month, the Exchange will assess the monthly production port fee, which may be prorated if subscribed to in the same month, and will also assess the Trading Ports used in Test Mode fee, which will be prorated from the date the change is made through the end of the month.

[6] 15 U.S.C. § 78f(b).

[7] 15 U.S.C. § 78f(b)(4) and (5).

[8] Securities Exchange Act Release No. 51808 at 37499 (June 9, 2005) (''Regulation NMS Adopting Release'').

[9] *NetCoalition* v. *SEC,* 615 F.3d 525 (D.C. Cir. 2010).

[10] *See NetCoalition,* at 534.

[11] *Id.* at 537.

[12] *Id.* at 539 (quoting ArcaBook Order, 73 FR at 74782–74783).

DR Port Fees

The fee assessed for DR Ports is reasonable because it is based on the cost incurred by the Exchange in purchasing and maintaining DR ports in the Chicago data center. Currently, the Exchange does not have a means to recoup its investment and costs associated with providing member firms with DR ports in the Chicago data center. Thus, the Exchange believes that the proposed fee is reasonable because the fee is intended to cover the Exchange's costs incurred in maintaining DR ports. The proposed fee may also allow the Exchange to make a profit to the extent the costs associated with purchasing and maintaining DR ports are covered.

The Exchange believes that the proposed fee is equitably allocated and not unfairly discriminatory because it will apply equally to all subscribers to DR ports based on the number of ports subscribed. Last, the Exchange notes that, for most member firms, subscription to DR ports is voluntary, and member firms may subscribe to as many or as few ports they believe is necessary. A select number of member firms chosen by the Exchange to participate in business continuity and disaster recovery plan testing pursuant to Rule 1170 will be obligated to subscribe to a DR port to participate in the annual test. Although subscription to DR ports is not voluntary for member firms selected for this once a year test, the Exchange believes that assessing the proposed fee is an equitable allocation and not unfairly discriminatory because such member firms will derive the same benefit as those members that voluntarily elect to subscribe to DR ports and such members may cancel their DR port subscription once their Rule 1170 testing obligation is satisfied.

Trading Ports used in Test Mode Fees

The proposed fee is also reasonable because it is based on the cost incurred by the Exchange in developing and maintaining multiple port connections, which are not used in the production environment and are designated as in test mode. As noted, the Exchange invests time and capital in initiating, monitoring and maintaining port connections to its system. Currently, the Exchange does not have a means to recoup its investment and costs associated with providing member firms with Trading Ports used in Test Mode. Thus, the Exchange believes that the proposed fee is reasonable because the fee is intended to cover the Exchange's costs incurred in maintaining test mode ports and is less than what is charged for a trading port in production mode. The proposed fee may also allow the Exchange to make a profit to the extent the costs associated with developing and maintaining Trading Ports used in Test Mode are covered. The Exchange believes that the proposed fee does not discriminate unfairly as it will promote efficiency in the market by incentivizing member firms to either place idle ports into production or cancel them if unneeded.

The proposed fee is also equitably allocated because all Exchange member firms that voluntarily elect to subscribe to trading ports, yet maintain them in test mode, will be charged the fee equally on a per-port basis. Last, the Exchange notes that subscription to Trading Ports used in Test Mode is voluntary, and member firms may subscribe to as many or as few ports they believe is necessary for their testing purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. In terms of inter-market competition, the Exchange notes that it operates in a highly competitive market in which market participants can readily favor competing venues if they deem fee levels at a particular venue to be excessive, or rebate opportunities available at other venues to be more favorable. In such an environment, the Exchange must continually adjust its fees to remain competitive with other exchanges and with alternative trading systems that have been exempted from compliance with the statutory standards applicable to exchanges. Because competitors are free to modify their own fees in response, and because market participants may readily adjust their order routing practices, the Exchange believes that the degree to which fee changes in this market may impose any burden on competition is extremely limited.

In this instance, the proposed fee merely allows the Exchange to recapture the costs associated with maintaining member ports that are in test mode and DR, and may provide the Exchange with a profit to the extent its costs are covered. The Trading Port used in Test Mode fee is applied uniformly to member firms that have such ports in the Carteret data center, where the Exchange incurs expenses to support this port configuration option.

The proposed fee will also promote efficient use of Trading Ports for testing. Similarly, the Exchange incurs greater costs in offering DR ports in the new Chicago data center, which the Exchange is seeking to cover. Any burden arising from the fees is necessary to cover costs associated with the location of the functionality in Chicago. If the changes proposed herein are unattractive to market participants, it is likely that the Exchange will lose market share as a result as member firms chose one of many alternative venues on which they may trade. Accordingly, the Exchange does not believe that the proposed changes will impair the ability of members or competing order execution venues to maintain their competitive standing in the financial markets.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(ii) of the Act.[13]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is: (i) Necessary or appropriate in the public interest; (ii) for the protection of investors; or (iii) otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–BX–2016–013 on the subject line.

Paper comments

- Send paper comments in triplicate to Secretary, Securities and Exchange

[13] 15 U.S.C. § 78s(b)(3)(A)(ii).

Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–BX–2016–013. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–BX–2016–013, and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[14]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05122 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[14] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77275; File No. SR–NYSEMKT–2016–28]

Self-Regulatory Organizations; NYSE MKT LLC; Notice of Filing and Immediate Effectiveness of a Proposed Change Amending the Fees for NYSE Amex Options Proprietary Market Data as They Apply to Federal Agency Customers

March 2, 2016.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on February 17, 2016, NYSE MKT LLC (the ''Exchange'' or ''NYSE MKT'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the fees for NYSE Amex Options proprietary market data as they apply to Federal agency customers. The proposed change is available on the Exchange's Web site at *www.nyse.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the NYSE Amex Options Proprietary Market Data Fee Schedule (''Fee Schedule''), to provide that market data fees do not apply to any Federal agency for their use of NYSE Amex Options real-time proprietary market data products. The term ''Federal agency'' as used in the Fee Schedule would include all Federal agencies subject to the Federal Acquisition Regulation (FAR),[4] as well as any Federal agency not subject to FAR that has promulgated its own procurement rules.[5]

The Exchange is proposing to specify that access fees, professional user fees and non-display fees do not apply to Federal agencies for those products to which those fees apply.[6] The proposal is designed to allow the Exchange to provide Federal agencies with NYSE Amex Options real-time proprietary market data products at no cost in support of Federal agencies' regulatory responsibilities. With the adoption of the proposed fee waiver, the Exchange is not waiving any of its contractual rights and all Federal agencies that subscribe to NYSE Amex Options real-time proprietary market data products will be required to execute the appropriate subscriber agreement, which include [sic], among other things, provisions against the redistribution of data.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[7] in general, and Sections 6(b)(4) and 6(b)(5) of the Act,[8] in particular, in that it provides an equitable allocation of reasonable fees among users and recipients of the data and is not

[4] FAR is the principal set of rules governing the process by which the U.S. federal government purchases goods and services.

[5] *See* 48 CFR 2.101. FAR defines ''Federal agency'' as ''any executive agency or any independent establishment in the legislative or judicial branch of the Government (except the Senate, the House of Representatives, the Architect of the Capitol, and any activities under the Architect's direction).'' ''Executive agency'' is defined as ''an executive department, a military department, or any independent establishment within the meaning of 5 U.S.C. 101, 102, and 104(1), respectively, and any wholly owned Government corporation within the meaning of 31 U.S.C. 9101.''

[6] These products are currently Amex Options Product and Amex Options Complex.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4), (5).

designed to permit unfair discrimination among customers, issuers, and brokers.

The Exchange believes the proposal to eliminate the access fees, display fees for professional users, and non-display fees associated with its proprietary market data products for customers that are Federal agencies is reasonable, equitable and not unfairly discriminatory because it is designed to facilitate federal government regulation without giving an undue advantage to one set of commercial users over another. The Exchange believes that it is reasonable to assess no fees to Federal agencies that subscribe to the Exchange's proprietary market data products because Federal agencies do not use the Exchange's proprietary market data for commercial gain, but only for regulatory purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. In setting the proposed fees, the Exchange considered the competitiveness of the market for proprietary data and all of the implications of that competition. The Federal agencies that will benefit from the proposed rule change, however, do not use the Exchange's proprietary market data products for commercial purposes and do not compete with commercial users of the data. The Exchange believes that it has considered all relevant factors and has not considered irrelevant factors in order to establish fair, reasonable, and not unreasonably discriminatory fees and an equitable allocation of fees among all users.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A) [9] of the Act and subparagraph (f)(2) of Rule 19b–4 [10] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B) [11] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–NYSEMKT–2016–28 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEMKT–2016–28. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEMKT–2016–28 and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05040 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

[11] 15 U.S.C. 78s(b)(2)(B).

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–77276; File No. SR–NYSEArca–2016–32]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change Amending the Fees for NYSE Arca Options Proprietary Market Data as They Apply to Federal Agency Customers

March 2, 2016.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on February 17, 2016, NYSE Arca, Inc. (the ''Exchange'' or ''NYSE Arca'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the fees for NYSE Arca Options proprietary market data as they apply to Federal agency customers. The proposed rule change is available on the Exchange's Web site at *www.nyse.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the NYSE Arca Options Proprietary Market Data Fee Schedule (''Fee Schedule''), to provide that market data fees do not apply to any Federal agency for their use of NYSE Arca Options real-time proprietary market data products. The term ''Federal agency'' as used in the Fee Schedule would include all Federal agencies subject to the Federal Acquisition Regulation (FAR),[4] as well as any Federal agency not subject to FAR that has promulgated its own procurement rules.[5]

The Exchange is proposing to specify that access fees, professional user fees and non-display fees do not apply to Federal agencies for those products to which those fees apply.[6] The proposal is designed to allow the Exchange to provide Federal agencies with NYSE Arca Options real-time proprietary market data products at no cost in support of Federal agencies' regulatory responsibilities. With the adoption of the proposed fee waiver, the Exchange is not waiving any of its contractual rights and all Federal agencies that subscribe to NYSE Arca Options real-time proprietary market data products will be required to execute the appropriate subscriber agreement, which includes, among other things, provisions against the redistribution of data.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[7] in general, and Sections 6(b)(4) and 6(b)(5) of the Act,[8] in particular, in that it provides an equitable allocation of reasonable fees among users and recipients of the data and is not designed to permit unfair discrimination among customers, issuers, and brokers.

The Exchange believes the proposal to eliminate the access fees, display fees for professional users, and non-display fees associated with its proprietary market data products for customers that are Federal agencies is reasonable, equitable and not unfairly discriminatory because it is designed to facilitate federal government regulation without giving an undue advantage to one set of commercial users over another. The Exchange believes that it is reasonable to assess no fees to Federal agencies that subscribe to the Exchange's proprietary market data products because Federal agencies do not use the Exchange's proprietary market data for commercial gain, but only for regulatory purposes.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. In setting the proposed fees, the Exchange considered the competitiveness of the market for proprietary data and all of the implications of that competition. The Federal agencies that will benefit from the proposed rule change, however, do not use the Exchange's proprietary market data products for commercial purposes and do not compete with commercial users of the data. The Exchange believes that it has considered all relevant factors and has not considered irrelevant factors in order to establish fair, reasonable, and not unreasonably discriminatory fees and an equitable allocation of fees among all users.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A)[9] of the Act and subparagraph (f)(2) of Rule 19b–4[10] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B)[11] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–NYSEArca–2016–32 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2016–32. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/*

[4] FAR is the principal set of rules governing the process by which the U.S. federal government purchases goods and services.

[5] *See* 48 CFR 2.101. FAR defines ''Federal agency'' as ''any executive agency or any independent establishment in the legislative or judicial branch of the Government (except the Senate, the House of Representatives, the Architect of the Capitol, and any activities under the Architect's direction).'' ''Executive agency'' is defined as ''an executive department, a military department, or any independent establishment within the meaning of 5 U.S.C. 101, 102, and 104(1), respectively, and any wholly owned Government corporation within the meaning of 31 U.S.C. 9101.''

[6] These products are currently Arca Options Product and Arca Options Complex.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4), (5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

[11] 15 U.S.C. 78s(b)(2)(B).

rules/sro.shtml). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2016–32 and should be submitted on or before March 29, 2016.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Robert W. Errett,

Deputy Secretary.

[FR Doc. 2016–05041 Filed 3–7–16; 8:45 am]

BILLING CODE 8011–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration # 14642 and # 14643]

Tennessee Disaster # TN–00088

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of Tennessee dated 02/25/2016.

Incident: Severe Storms, Tornadoes, and Heavy Precipitation.

Incident Period: 12/23/2015 through 12/28/2015.

Effective Date: 02/25/2016.

Physical Loan Application Deadline Date: 04/25/2016.

Economic Injury (EIDL) Loan Application Deadline Date: 11/25/2016.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Wayne.

Contiguous Counties:

Tennessee: Decatur, Hardin, Lawrence Lewis, Perry.

Alabama: Lauderdale.

The Interest Rates are:

	Percent
For Physical Damage	
Homeowners With Credit Available Elsewhere	3.625
Homeowners Without Credit Available Elsewhere	1.813
Businesses With Credit Available Elsewhere	6.000
Businesses Without Credit Available Elsewhere	4.000
Non-Profit Organizations With Credit Available Elsewhere	2.625
Non-Profit Organizations Without Credit Available Elsewhere	2.625
For Economic Injury	
Businesses & Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000
Non-Profit Organizations Without Credit Available Elsewhere	2.625

The number assigned to this disaster for physical damage is 14642 B and for economic injury is 14643 0.

The States which received an EIDL Declaration # are Tennessee, Alabama.

(Catalog of Federal Domestic Assistance Numbers 5900)

Dated: February 25, 2016.

Maria Contreras-Sweet,

Administrator.

[FR Doc. 2016–04853 Filed 3–7–16; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Public Notice: 9463]

30-Day Notice of Proposed Information Collection: INTERNational Connections

ACTION: Notice of request for public comment and submission to OMB of proposed collection of information.

SUMMARY: The Department of State has submitted the information collection described below to the Office of Management and Budget (OMB) for approval. In accordance with the Paperwork Reduction Act of 1995 we are requesting comments on this collection from all interested individuals and organizations. The purpose of this Notice is to allow 30 days for public comment.

DATES: Submit comments directly to the Office of Management and Budget (OMB) up to April 7, 2016.

ADDRESSES: Direct comments to the Department of State Desk Officer in the Office of Information and Regulatory Affairs at the Office of Management and Budget (OMB). You may submit comments by the following methods:

- *Email: oira_submission@omb.eop.gov.* You must include the DS form number, information collection title, and the OMB control number in the subject line of your message.
- *Fax:* 202–395–5806. Attention: Desk Officer for Department of State.

FOR FURTHER INFORMATION CONTACT: Direct requests for additional information regarding the collection listed in this notice, including requests for copies of the proposed collection instrument and supporting documents, to Heather Rudow, 2401 E Street NW., Washington, DC 20520, who may be reached on 202–261–8953 or at *rudowh@state.gov.*

SUPPLEMENTARY INFORMATION:

- *Title of Information Collection:* INTERNational Connections.
- *OMB Control Number:* 1405–0190.
- *Type of Request:* Revision of a Currently Approved Collection.
- *Originating Office:* Bureau of Human Resources, Office of Recruitment, Examination and Employment (HR/REE).
- *Form Number:* DS–5103.
- *Respondents:* Current participants and alumni of the U.S. Department of State's student programs, including internships, Pickerings, Rangels, Pathways, etc. and Department Employees.
- *Estimated Number of Respondents:* 1,000.
- *Estimated Number of Responses:* 1,000.
- *Average Time Per Response:* 15 minutes.
- *Total Estimated Burden Time:* 250 hours.
- *Frequency:* On occasion.
- *Obligation to Respond:* Voluntary.

We are soliciting public comments to permit the Department to:

- Evaluate whether the proposed information collection is necessary for the proper functions of the Department.
- Evaluate the accuracy of our estimate of the time and cost burden for

[12] 17 CFR 200.30–3(a)(12).

this proposed collection, including the validity of the methodology and assumptions used.

• Enhance the quality, utility, and clarity of the information to be collected.

• Minimize the reporting burden on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Please note that comments submitted in response to this Notice are public record. Before including any detailed personal information, you should be aware that your comments as submitted, including your personal information, will be available for public review.

Abstract of Proposed Collection

The Department's student internship programs provide a key source of potential prospects who have an interest in, and are qualified, to become future Department employees. Naturally, HR/REE wants to strengthen and maintain its connections to this group, fostering and mentoring a pool of prospects from which to obtain successful recruits.

In June 2008, HR/REE surveyed over 3,500 former interns who served from 2005 through spring 2008. The intern alumni were queried as to their motivation in seeking an internship, whether or not they had pursued a career with either the Foreign Service or Civil Service, and what their recommendations would be for the best ways for the Department to maintain contact after the conclusion of their internships. Intern alumni endorse continued contact with Department representatives mainly through electronic means and Web site reminders of career opportunities.

In an effort to address these findings and provide viable solutions to improving student engagement prior to, during and following an internship, the Department developed an intern engagement strategy that will ultimately result in a measurable conversion of interns into Department hires for the Foreign or Civil Service. The foundation of this strategy is INTERNational Connections, a web-based career networking site for current and former interns as well as Department employees that collects pertinent information about them, their experiences and their career goals.

Methodology

Users register online at *https://internconnect.careers.state.gov* and create a profile that includes: full name, program status, names of colleges attended, major/minor, where the user is from, current post, year graduated, career goals and interests, personal interests, career path, bureau, job title, professional experience and languages the user can speak. The respondents are current and former interns, as well as Department employees.

Dated: February 29, 2016.

Derwood Staeben,

Executive Director, HR/REE, Department of State.

[FR Doc. 2016–05180 Filed 3–7–16; 8:45 am]

BILLING CODE 4710–15–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Reallocation of Unused Fiscal Year 2016 Tariff-Rate Quota Volume for Raw Cane Sugar

AGENCY: Office of the United States Trade Representative.

ACTION: Notice.

SUMMARY: The Office of the United States Trade Representative (USTR) is providing notice of country-by-country reallocations of the fiscal year (FY) 2016 in-quota quantity of the World Trade Organization (WTO) tariff-rate quota (TRQ) for imported raw cane sugar.

DATES: Effective: March 8, 2016.

ADDRESSES: Inquiries may be mailed or delivered to Ronald Baumgarten, Director of Agricultural Affairs, Office of Agricultural Affairs, Office of the United States Trade Representative, 600 17th Street NW., Washington, DC 20508.

FOR FURTHER INFORMATION CONTACT: Ronald Baumgarten, Office of the United States Trade Representative, Office of Agricultural Affairs, telephone: 202–395–9583 or facsimile: 202–395–4579.

SUPPLEMENTARY INFORMATION: Pursuant to Additional U.S. Note 5 to Chapter 17 of the Harmonized Tariff Schedule of the United States (HTS), the United States maintains WTO TRQs for imports of raw cane and refined sugar.

Section 404(d)(3) of the Uruguay Round Agreements Act (19 U.S.C. 3601(d)(3)) authorizes the President to allocate the in-quota quantity of a TRQ for any agricultural product among supplying countries or customs areas. The President delegated this authority to the United States Trade Representative under Presidential Proclamation 6763 (60 FR 1007).

On June 15, 2015, the Secretary of Agriculture established the FY 2016 TRQ for imported raw cane sugar at the minimum to which the United States is committed pursuant to the World Trade Organization (WTO) Uruguay Round Agreements (1,117,195 metric tons raw value (MTRV)). On July 15, 2015, USTR provided notice of country-by-country allocations of the FY 2016 in-quota quantity of the WTO TRQ for imported raw cane sugar. Based on consultation with quota holders, USTR has determined to reallocate 86,533 MTRV of the original TRQ quantity from those countries that are unable to fill their FY 2016 allocated raw cane sugar quantities. USTR is allocating the 86,533 MTRV to the following countries in the amounts specified below:

Country	FY 2016 reallocation
Argentina	3,884
Australia	7,497
Belize	994
Brazil	13,097
Colombia	2,168
Costa Rica	1,355
Dominican Republic	15,897
Ecuador	994
El Salvador	2,348
Fiji	813
Guatemala	4,336
Guyana	1,084
Honduras	903
India	723
Jamaica	994
Malawi	903
Mauritius	1,084
Mozambique	1,174
Nicaragua	1,897
Panama	2,619
Peru	3,703
Philippines	12,194
South Africa	2,078
Swaziland	1,445
Thailand	1,265
Zimbabwe	1,084

These allocations are based on the countries' historical shipments to the United States. The allocations of the raw cane sugar WTO TRQ to countries that are net importers of sugar are conditioned on receipt of the appropriate verifications of origin. Certificates for quota eligibility must accompany imports from any country for which an allocation has been provided.

Conversion factor: 1 metric ton = 1.10231125 short tons.

Michael Froman,

United States Trade Representative.

[FR Doc. 2016–05203 Filed 3–7–16; 8:45 am]

BILLING CODE 3290–F6–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Aviation Rulemaking Advisory Committee; Meeting

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of Aviation Rulemaking Advisory Committee (ARAC) meeting.

SUMMARY: The FAA is issuing this notice to advise the public of a meeting of the ARAC.

DATES: The meeting will be held on March 23, 2016, starting at 1:00 p.m. Eastern Daylight Savings Time. Arrange oral presentations by March 16, 2016.

ADDRESSES: The meeting will take place at the Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591, 10th floor, MacCracken Conference Room.

FOR FURTHER INFORMATION CONTACT: Giles Strickler, Federal Aviation Administration, 490 L'Enfant Plaza SW., Washington, DC 20024, telephone (202) 267- 5883; fax (202) 267–5075; email *Giles.D.Strickler@faa.gov.*

SUPPLEMENTARY INFORMATION: Pursuant to Section 10(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App. 2), we are giving notice of a meeting of the ARAC taking place on March 23, 2016, at the Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591.

The Agenda includes:

1. Recommendation Report
   a. Rotorcraft Occupant Protection Working Group Interim Report
   b. Airman Certification Systems Working Group Interim Report
2. Status Reports From Active Working Groups
   a. Aircraft Systems Information Security/Protection Working Group
   b. Air Traffic Controller Training Working Group
   c. Transport Airplane and Engine Subcommittee
   i. Airworthiness Assurance Working Group
   ii. Engine Harmonization Working Group- Engine Endurance Testing Requirements
   iii. Flight Test Harmonization Working Group—Phase 2 Tasking
   iv. Transport Airplane Metallic and Composite Structures Working Group—Transport Airplane Damage-Tolerance and Fatigue Evaluation
   v. Transport Airplane Crashworthiness and Ditching Evaluation Working Group
3. New Tasks
   a. Rotorcraft Bird Strike Working Group
   b. Special Cargo
   i. Special Cargo Report
   ii. Load Master Certification Working Group
4. Status Report from the FAA

Attendance is open to the interested public but limited to the space available. Please confirm your attendance with the person listed in the **FOR FURTHER INFORMATION CONTACT** section no later than March 16, 2016. Please provide the following information: full legal name, country of citizenship, and name of your industry association, or applicable affiliation. If you are attending as a public citizen, please indicate so.

For persons participating by telephone, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section by email or phone for the teleconference call-in number and passcode. Callers are responsible for paying long-distance charges.

The public must arrange by March 16, 2016 to present oral statements at the meeting. The public may present written statements to the Aviation Rulemaking Advisory Committee by providing 25 copies to the Designated Federal Officer, or by bringing the copies to the meeting.

If you are in need of assistance or require a reasonable accommodation for this meeting, please contact the person listed under the heading **FOR FURTHER INFORMATION CONTACT**. Sign and oral interpretation, as well as a listening device, can be made available if requested 10 calendar days before the meeting.

Issued in Washington, DC, on March 2, 2016.

James Crotty,

Designated Federal Officer, Aviation Rulemaking Advisory Committee.

[FR Doc. 2016–05081 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016 0023]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel MISTY; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0023. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–465, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov* .

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel MISTY is:

Intended Commercial Use of Vessel: ''6-passenger vessel for Bed and Breakfast and short duration cruises in protected waters.'' Geographic Region: ''California''

The complete application is given in DOT docket MARAD–2016–0023 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act

Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.
Dated: February 25, 2016.

Gabriel Chavez,

Acting Secretary,Maritime Administration.

[FR Doc. 2016–05110 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016 0021]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel TENACIOUS; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0021. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel TENACIOUS is:

Intended Commercial Use of Vessel:
''Coastal charter for up to 6 passengers. sail getaway excursion vacation''

Geographic Region: ''Maine, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Florida''

The complete application is given in DOT docket MARAD–2016–0021 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.
Dated: February 25, 2016.

Gabriel Chavez,

Acting Secretary, Maritime Administration.

[FR Doc. 2016–05111 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016 0025]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel BIG GAME; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0025. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except Federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel BIG GAME is:

Intended Commercial Use of Vessel: 6 Pack Charter

Geographic Region: ''RHODE ISLAND''

The complete application is given in DOT docket MARAD–2016–0025 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels.

If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the Federal Register published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.

Dated: March 1, 2016.

T. Mitchell Hudson, Jr.,

Secretary, Maritime Administration.

[FR Doc. 2016–05112 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016 0020]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel HYPATIA; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0020. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except Federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.Carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel HYPATIA is:

Intended Commercial Use of Vessel: ''Hypatia is a classic sailing yacht which I would like to occasionally charter with myself or husband as licensed captains. We would carry no more than 6 passengers on private charters mainly on Naragansett Bay in Rhode Island, and occasionally along the New England coast. The boat may also be used in photography shoots and advertising.''

Geographic Region: Rhode Island, Massachusetts, Maine, New Hampshire, Connecticut''

The complete application is given in DOT docket MARAD–2016–0020 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.

Dated: February 25, 2016.

Gabriel Chavez,

Acting Secretary, Maritime Administration.

[FR Doc. 2016–05107 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016–0022]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel CABERNET SKY; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0022. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel CABERNET SKY is:

Intended Commercial Use of Vessel: ''Passenger Charter Service'' GEOGRAPHIC REGION: ''California''.

The complete application is given in DOT docket MARAD–2016–0022 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in

accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.

Dated: February 25, 2016.

Gabriel Chavez,

Acting Secretary, Maritime Administration.

[FR Doc. 2016–05109 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016 0019]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel ALYKAT; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0019. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.Carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel ALYKAT is:

Intended Commercial Use Of Vessel: ''Husband and wife team would like to give sailing lessons as well as day sails. The vessel will also be available for short term captained charters.''

Geographic Region: Rhode Island, Massachusetts, New York, South Carolina, Florida''.

The complete application is given in DOT docket MARAD–2016–0019 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator.

Dated: February 25, 2016.

Gabriel Chavez,

Acting Secretary, Maritime Administration.

[FR Doc. 2016–05108 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[Docket No. MARAD–2016 0024]

Requested Administrative Waiver of the Coastwise Trade Laws: Vessel BANDIDO; Invitation for Public Comments

AGENCY: Maritime Administration, Department of Transportation.

ACTION: Notice.

SUMMARY: As authorized by 46 U.S.C. 12121, the Secretary of Transportation, as represented by the Maritime Administration (MARAD), is authorized to grant waivers of the U.S.-build requirement of the coastwise laws under certain circumstances. A request for such a waiver has been received by MARAD. The vessel, and a brief description of the proposed service, is listed below.

DATES: Submit comments on or before April 7, 2016.

ADDRESSES: Comments should refer to docket number MARAD–2016–0024. Written comments may be submitted by hand or by mail to the Docket Clerk, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. You may also send comments electronically via the Internet at *http://www.regulations.gov.* All comments will become part of this docket and will be available for inspection and copying at the above address between 10 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. An electronic version of this document and all documents entered into this docket is available on the World Wide Web at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Bianca Carr, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Avenue SE., Room W23–453, Washington, DC 20590. Telephone 202–366–9309, Email *Bianca.carr@dot.gov.*

SUPPLEMENTARY INFORMATION: As described by the applicant the intended service of the vessel BANDIDO is:

Intended Commercial Use Of Vessel: ''Sightseeing charter excursions''.

Geographic Region: ''Maine, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Delaware, District of Columbia, Maryland, Virginia, North Carolina, South Carolina, Georgia, Florida''.

The complete application is given in DOT docket MARAD–2016–0024 at *http://www.regulations.gov.* Interested parties may comment on the effect this action may have on U.S. vessel builders or businesses in the U.S. that use U.S.-flag vessels. If MARAD determines, in accordance with 46 U.S.C. 12121 and MARAD's regulations at 46 CFR part 388, that the issuance of the waiver will have an unduly adverse effect on a U.S.-vessel builder or a business that uses U.S.-flag vessels in that business, a waiver will not be granted. Comments should refer to the docket number of this notice and the vessel name in order for MARAD to properly consider the comments. Comments should also state the commenter's interest in the waiver application, and address the waiver criteria given in § 388.4 of MARAD's regulations at 46 CFR part 388.

Privacy Act

Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

By Order of the Maritime Administrator
Dated: March 1, 2016.

T. Mitchell Hudson, Jr.,

Secretary, Maritime Administration.

[FR Doc. 2016–05113 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[U.S. DOT Docket No. NHTSA–2016–0011]

Reports, Forms, and Record Keeping Requirements

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Request for public comment on proposed collection of information.

SUMMARY: Before a Federal agency can collect certain information from the public, it must receive approval from the Office of Management and Budget (OMB). Under procedures established by the Paperwork Reduction Act of 1995, before seeking OMB approval, Federal agencies must solicit public comment on proposed collections of information, including extensions and reinstatements of previously approved collections.

This document describes one collection of information for which NHTSA intends to seek OMB approval.

DATES: Comments must be received on or before May 9, 2016.

ADDRESSES: You may submit comments identified by DOT Docket ID Number NHTSA–2016–0011 using any of the following methods:

Electronic submissions: Go to *http://www.regulations.gov.* Follow the online instructions for submitting comments.

Mail: Docket Management Facility, M–30, U.S. Department of Transportation, 1200 New Jersey Avenue SE., West Building Ground Floor, Room W12–140, Washington, DC 20590.

Hand Delivery: West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Fax: 1–202–493–2251.

Instructions: Each submission must include the Agency name and the Docket number for this Notice. Note that all comments received will be posted without change to *http://www.regulations.gov* including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Alan Block, Office of Behavioral Safety Research (NPD–310), National Highway Traffic Safety Administration, 1200 New Jersey Avenue SE., W46–499, Washington, DC 20590. Mr. Block's phone number is 202–366–6401 and his email address is *Alan.Block@dot.gov.*

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995, before an agency submits a proposed collection of information to OMB for approval, it must publish a document in the **Federal Register** providing a 60-day comment period and otherwise consult with members of the public and affected agencies concerning each proposed collection of information. The OMB has promulgated regulations describing what must be included in such a document. Under OMB's regulations (at 5 CFR 1320.8(d)), an agency must ask for public comment on the following:

(i) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(ii) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(iii) how to enhance the quality, utility, and clarity of the information to be collected; and

(iv) how to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

In compliance with these requirements, NHTSA asks public comment on the following proposed collection of information:

Title: Awareness & Availability of Child Passenger Safety Information Resources (AACPSIR).

Type of Request: New information collection requirement.

OMB Clearance Number: None.

Form Number: NHTSA Forms 1333 and 1334.

Requested Expiration Date of Approval: 3 years from date of approval.

Summary of the Collection of Information: The National Highway Traffic Safety Administration (NHTSA) proposes to conduct a national web-based survey to estimate parent and caregiver general knowledge of child passenger safety (CPS) information resources, awareness and use of child restraint system (CRS) inspection stations, and reported barriers to CRS inspection station use. The survey will also examine the relationship between parent and caregiver confidence in installing CRSs, risk perception, and intent to visit an inspection station. NHTSA will contact a maximum of 32,000 households to obtain 1,400 completed interviews. NHTSA will use a 5 minute screening instrument to determine survey eligibility. Households will be eligible if they have at least one adult who regularly travels with a child between the ages of 0 and 9 in their personal vehicles. Households with an eligible participant will be asked by NHTSA to complete a 15 minute interview. Spanish translation services will be provided.

Description of the Need for the Information and Proposed Use of the Information—NHTSA was established by the Highway Safety Act of 1970 (*23 U.S.C. 101*) to carry out a Congressional mandate to reduce the mounting number of deaths, injuries, and economic losses resulting from motor vehicle crashes on the Nation's highways. As part of this statutory mandate, NHTSA is authorized to

conduct research as a foundation for the development of motor vehicle standards and traffic safety programs.

Data from NHTSA's Fatality Analysis Reporting System show that an average of 3 children under the age of 14 died each day in traffic crashes in 2013 and an estimated 470 children were injured. Child restraint systems (CRSs) are effective at reducing the risk of injury during motor vehicle crashes. Research has shown a 28% reduction in risk of death for children (aged 2–6 years) compared to seat belts when CRSs are installed correctly. Studies have estimated rates of improper installation of CRSs to be in the range of 70–80 percent.

Many information resources are available to aid parents and caregivers with proper child restraint system selection and installation, including hands-on instruction. In 1998, NHTSA implemented a program for training and certifying child passenger safety technicians (CPSTs). Presently, Safe Kids Worldwide hosts Child Car Seat Inspection Stations nationwide which provide parents and caregivers an opportunity to receive one-on-one instruction regarding proper use and installation of child restraints from a certified CPST. Research has shown that hands-on instruction on CRS installation is effective in reducing misuse of seats. Unfortunately, this resource seems to be underutilized. Only about one out of ten drivers interviewed for the National Child Restraint Use Special Study (NCRUSS) reported having their CRS inspected at an inspection station.

At present, it is unclear what deters and what encourages use of Child Car Seat Inspection Stations and CPSTs. One potential barrier is parent/caregiver overconfidence leading to overconfident parents and caregivers not recognizing the need to visit an inspection station or CPST. One example of this is the NCRUSS where misuse was observed in 46% of cases, but where most drivers reported being confident or very confident that they chose the correct car seat/booster seat and installed the car seat/booster seat correctly. Potential barriers to use don't stop with overconfidence; they could also include logistical and practical matters, such as awareness and accessibility.

Identifying and better understanding the barriers that result in underutilization of inspection stations will allow NHTSA and other child passenger safety stakeholders to develop effective programs that promote and encourage use of this important life-saving resource.

Description of the Likely Respondents (Including Estimated Number, and Proposed Frequency of Response to the Collection of Information)—Under this proposed data collection, the potential respondent universe would be people aged 18 years or older who regularly transport children between the ages of 0 and 9 in their personal vehicles. NHTSA will send survey requests to a sufficient number of households to obtain 1,400 completed interviews. The requests will be sent via postal mail.

Respondents within a household would not be randomly selected. Rather, the screener would ask the member of the household who most frequently drives children to complete the survey. NHTSA considers this to be the person in the household most likely to seek CPS information and pursue CPS training at an inspection station, and therefore the most appropriate respondent for this survey. Each respondent would complete a single survey; there will be no request for additional follow-up information or response.

Throughout the project, the privacy of all participants would be protected. Access to the online instrument would be controlled using an alphanumeric PIN, with access restricted to using encrypted connection via Secure Sockets Layer (SSL) certificates. To protect the online instruments from break-in attempts, the public site would feature automatic access lockdown after too many unsuccessful login attempts are performed within a short amount of time. Similarly, once an interview is completed, the survey would no longer be accessible to respondents using their PINs. These two measures protect respondent responses from being compromised.

Personally-identifiable information such as the postal address of sample members would be kept separate from the data collected, and would be stored in restricted folders on secure password protected servers that are only accessible to study staff who have need to access such information. In addition, all data collected from respondents will be reported in aggregate, and identifying information would not be used in any reports resulting from this data collection effort. Rigorous de-identification procedures would be used during summary and feedback stages to prevent respondents from being identified through reconstructive means.

Estimate of the Total Annual Reporting and Record Keeping Burden Resulting From the Collection of Information—NHTSA estimates that the total respondent burden for this data collection would be 942 hours. A sufficient number of invitation letters would be distributed for 7,000 potential respondents to log onto the Web site and take a 5 minute eligibility screener (7,000 * 5 minutes = 35,000 minutes/60 = 583 hours). Of those who take the eligibility screener, NHTSA estimates that 1,400 would complete the full survey which would average 15 minutes in length (1,400 * 15 minutes = 21,000 minutes/60 = 350 hours). The data collection would also include 9 hours of burden for 9 people to complete usability testing at 1 hour each to aid survey instrument development (9 * 1 hour = 9 hours). The participants would not incur any reporting cost from the information collection. The participants would also not incur any record keeping burden or record keeping cost from the information collection.

Authority: 44 U.S.C. Section 3506(c)(2)(A).

Issued in Washington, DC on March 3, 2016.

Jeff Michael,

Associate Administrator, Research and Program Development.

[FR Doc. 2016–05091 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

Petition for Exemption From the Federal Motor Vehicle Theft Prevention Standard; American Honda Motor Co., Inc.

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Grant of petition for exemption.

SUMMARY: This document grants in full the American Honda Motor Co., Inc.'s (Honda) petition for an exemption of the Pilot vehicle line in accordance with 49 CFR part 543, *Exemption from Vehicle Theft Prevention Standard.* This petition is granted because the agency has determined that the antitheft device to be placed on the line as standard equipment is likely to be as effective in reducing and deterring motor vehicle theft as compliance with the parts-marking requirements of the 49 CFR part 541, *Federal Motor Vehicle Theft Prevention Standard* (Theft Prevention Standard).

DATES: The exemption granted by this notice is effective beginning with the 2017 model year (MY).

FOR FURTHER INFORMATION CONTACT: Ms. Deborah Mazyck, Office of International

Policy, Fuel Economy and Consumer Programs, NHTSA, West Building, W43–443, 1200 New Jersey Avenue SE., Washington, DC 20590. Ms. Mazyck's phone number is (202) 366–4139. Her fax number is (202) 493–2990.

SUPPLEMENTARY INFORMATION: In a petition dated November 6, 2015, Honda requested an exemption from the parts-marking requirements of the Theft Prevention Standard for the Pilot vehicle line beginning with MY 2017. The petition requested an exemption from parts-marking pursuant to 49 CFR part 543, *Exemption from Vehicle Theft Prevention Standard,* based on the installation of an antitheft device as standard equipment for the entire vehicle line.

Under 49 CFR part 543.5(a), a manufacturer may petition NHTSA to grant an exemption for one vehicle line per model year. In its petition, Honda provided a detailed description and diagram of the identity, design, and location of the components of the antitheft device for the Pilot vehicle line. Honda stated that its vehicle line will offer a front-wheel drive and an all-wheel drive variation. Honda further stated that its MY 2017 Pilot vehicle line will be installed with a transponder-based, engine immobilizer antitheft device as standard equipment. Honda also stated that the Pilot vehicle line will be equipped with a ''smart entry with push button start'' ignition system (''smart entry'') and an audible and visible vehicle security system as standard equipment on the entire line. Key components of the antitheft device will include a passive immobilizer, ''smart entry'' remote, powertrain control module (PCM) and an Immobilizer Entry System (IMOES).

Honda's submission is considered a complete petition as required by 49 CFR 543.7, in that it meets the general requirements contained in § 543.5 and the specific content requirements of § 543.6.

In addressing the specific content requirements of § 543.6, Honda provided information on the reliability and durability of its proposed device. To ensure reliability and durability of the device, Honda conducted tests based on its own specified standards. Honda provided a detailed list of the tests it used to validate the integrity, durability and reliability of the device and believes that it follows a rigorous development process to ensure that its antitheft device will be reliable and robust for the life of the vehicle. Honda stated that its device does not require the presence of a ''smart entry'' remote battery to function nor does it have any moving parts (*i.e.,* the PCM, IMOES, ignition key, ''smart entry'' remote and the electrical components are found within its own housing units), which it believes reduces the chance for deterioration and wear from normal use.

Honda stated that its immobilizer device is always active without requiring any action from the vehicle operator, until the vehicle is started using a matching ''smart entry'' remote. Deactivation occurs when a ''smart entry'' remote with matching codes is placed within operating range. Ignition of the ''smart entry'' system is started by pushing the engine start/stop button located to the right of the steering wheel on the vehicle dashboard. Specifically, Honda stated that the ''smart entry'' system automatically checks for the immobilizer code when the ''smart entry'' remote is within operating range (inside the vehicle, close to the doors or window or in close proximity outside the vehicle's exterior) and the vehicle is started by pushing the engine start/stop button. The matching code is validated by the IMOES, allowing the engine to start. Honda further states that if a ''smart entry'' remote without a matching code is placed inside the operating range and the engine start/stop button is pushed, the PCM will prevent fueling and starting of the engine. Additionally, the ignition immobilizer telltale indicator will begin flashing on the meter panel. Honda further stated that activation of its ''smart entry'' system occurs when the start/stop button is switched to the ''OFF'' position.

Honda stated that it will install an audible and visible vehicle security system as standard equipment on all its Pilot vehicles to monitor any attempts of unauthorized entry and to attract attention to an unauthorized person attempting to enter its vehicles without the use of a key or a ''smart entry'' remote. Specifically, Honda stated that whenever an attempt is made to open one of its vehicle doors, hood or trunk without turning a key in the key cylinder, or using the ''smart entry'' remote to disarm the vehicle, the vehicle's horn will sound and its lights will flash. The vehicle security system is activated when all of the doors are locked and the hood and trunk are closed and locked. Honda's vehicle security system is deactivated by using the key fob buttons to unlock the vehicle doors or having the ''smart entry'' remote within operating range when the operator grabs either of the vehicle's front door handles.

Honda believes that additional levels of reliability, durability and security will be accomplished because its ''smart entry'' remote will utilize rolling codes for the lock and unlock functions of its vehicles. Honda stated that it will also equip its vehicle line with a hood release located inside the vehicle, counterfeit resistant vehicle identification number (VIN) plates and secondary VINs as standard equipment.

In support of its belief that its antitheft device will be as or more effective in reducing and deterring vehicle theft than the parts-marking requirement, Honda referenced data showing several instances of the effectiveness of its proposed immobilizer device. Honda first installed an immobilizer device as standard equipment on its MY 2003 Pilot vehicles and referenced NHTSA's theft rate data for MYs 2003–2012 showing a consistent rate of thefts well below the median of 3.5826 since the installation of its immobilizer device. NHTSA notes that the theft rates for MYs 2011, 2012, and 2013 Pilot vehicle line are 0.3844, 0.9846 and 1.2111 respectively. Using an average of three MYs' theft data (2011–2013), the theft rate for the Pilot vehicle line is well below the median at 0.8600. Additionally, Honda referenced the Highway Loss Data Institute's 2004–2015 Insurance Theft Report showing an overall reduction in theft rates for the Honda Pilot vehicles after introduction of the immobilizer device.

Additionally, Honda stated that the immobilizer device proposed for the 2017 Pilot is similar to the design offered on its Honda Civic, Honda Accord and Honda CR–V vehicles. The agency granted the petitions for the Honda Civic vehicle line in full beginning with MY 2014 (see 61 FR 19363, March 29, 2013), the Honda Accord vehicle line beginning with MY 2015 (see 79 FR 18409, April 1, 2014), and the Honda CR–V vehicle line beginning with MY 2016 (see 80 FR 3733, January 23, 2015). The agency notes that the average theft rate for the Honda Civic, Accord and CR–V vehicle lines using three MYs' data (MYs 2011 through 2013) are 0.8030, 0.7496 and 0.3119 respectively.

Based on the evidence submitted by Honda on its antitheft device, the agency believes that the antitheft device for the Pilot vehicle line is likely to be as effective in reducing and deterring motor vehicle theft as compliance with the parts-marking requirements of the Theft Prevention Standard.

Pursuant to 49 U.S.C. 33106 and 49 CFR 543.7 (b), the agency grants a petition for exemption from the parts-marking requirements of Part 541 either in whole or in part, if it determines that, based upon substantial evidence, the

standard equipment antitheft device is likely to be as effective in reducing and deterring motor vehicle theft as compliance with the parts-marking requirements of Part 541. The agency finds that Honda has provided adequate reasons for its belief that the antitheft device for the Honda Pilot vehicle line is likely to be as effective in reducing and deterring motor vehicle theft as compliance with the parts-marking requirements of the Theft Prevention Standard. This conclusion is based on the information Honda provided about its device.

Based on the supporting evidence submitted by Honda on its device, the agency believes that the antitheft device for the Pilot vehicle line is likely to be as effective in reducing and deterring motor vehicle theft as compliance with the parts-marking requirements of the Theft Prevention Standard (49 CFR 541). The agency concludes that the device will provide the five types of performance listed in § 543.6(a)(3): promoting activation; attract attention to the efforts of an unauthorized person to enter or move a vehicle by means other than a key; preventing defeat or circumvention of the device by unauthorized persons; preventing operation of the vehicle by unauthorized entrants; and ensuring the reliability and durability of the device.

For the foregoing reasons, the agency hereby grants in full Honda's petition for exemption for the Pilot vehicle line from the parts-marking requirements of 49 CFR part 541, beginning with the 2017 model year vehicles. The agency notes that 49 CFR part 541, Appendix A–1, identifies those lines that are exempted from the Theft Prevention Standard for a given model year. 49 CFR part 543.7(f) contains publication requirements incident to the disposition of all Part 543 petitions. Advanced listing, including the release of future product nameplates, the beginning model year for which the petition is granted and a general description of the antitheft device is necessary in order to notify law enforcement agencies of new vehicle lines exempted from the parts-marking requirements of the Theft Prevention Standard.

If Honda decides not to use the exemption for this line, it must formally notify the agency. If such a decision is made, the line must be fully marked according to the requirements under 49 CFR parts 541.5 and 541.6 (marking of major component parts and replacement parts).

NHTSA notes that if Honda wishes in the future to modify the device on which this exemption is based, the company may have to submit a petition to modify the exemption. Part 543.7(d) states that a Part 543 exemption applies only to vehicles that belong to a line exempted under this part and equipped with the antitheft device on which the line's exemption is based. Further, Part 543.9(c)(2) provides for the submission of petitions ''to modify an exemption to permit the use of an antitheft device similar to but differing from the one specified in that exemption.''

The agency wishes to minimize the administrative burden that Part 543.9(c)(2) could place on exempted vehicle manufacturers and itself. The agency did not intend in drafting Part 543 to require the submission of a modification petition for every change to the components or design of an antitheft device. The significance of many such changes could be *de minimis.* Therefore, NHTSA suggests that if the manufacturer contemplates making any changes, the effects of which might be characterized as *de minimis,* it should consult the agency before preparing and submitting a petition to modify.

Issued in Washington, DC under authority delegated in 49 CFR 1.95.

Raymond R. Posten,

Associate Administrator for Rulemaking.

[FR Doc. 2016–05069 Filed 3–7–16; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF THE TREASURY

Bureau of the Fiscal Service

Proposed Collection of Information: Application for Recognition as Natural Guardian of a Minor Not Under Legal Guardianship and for Disposition of Minor's Interest in Registered Securities

AGENCY: Bureau of the Fiscal Service, Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A). Currently the Bureau of the Fiscal Service within the Department of the Treasury is soliciting comments concerning the Application for Recognition as Natural Guardian of a Minor Not Under Legal Guardianship and for Disposition of Minor's Interest in Registered Securities.

DATES: Written comments should be received on or before May 9, 2016 to be assured of consideration.

ADDRESSES: Direct all written comments and requests for further information to Bureau of the Fiscal Service, Bruce A. Sharp, 200 Third Street A4–A, Parkersburg, WV 26106–1328, or *bruce.sharp@fiscal.treasury.gov.*

SUPPLEMENTARY INFORMATION:

Title: Application for Recognition as Natural Guardian of a Minor Not Under Legal Guardianship and for Disposition of Minor's Interest in Registered Securities.

OMB Number: 1530–0041 (Previously approved as 1535–0105 as a collection conducted by Department of the Treasury/Bureau of the Public Debt.)

Transfer of OMB Control Number: The Bureau of Public Debt (BPD) and the Financial Management Service (FMS) have consolidated to become the Bureau of the Fiscal Service (Fiscal Service). Information collection requests previously held separately by BPD and FMS will now be identified by a 1530 prefix, designating Fiscal Service.

Form Number: FS Form 2481.

Abstract: The information is collected to apply for recognition as a natural guardian and request disposition of securities belonging to a minor in situations where a natural guardian is no longer acting or a legal representative is not appointed.

Current Actions: Extension of a previously approved collection.

Type of Review: Emergency.

Affected Public: Households and Individuals.

Estimated Number of Respondents: 1,250.

Estimated Time per Respondent: 10 minutes.

Estimated Total Annual Burden Hours: 208.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital

or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Dated: March 2, 2016.

Bruce A. Sharp,

Bureau Clearance Officer.

[FR Doc. 2016–05035 Filed 3–7–16; 8:45 am]

BILLING CODE 4810–AS–P

DEPARTMENT OF THE TREASURY

Bureau of the Fiscal Service

Proposed Collection of Information: Minority Bank Deposit Program (MBDP) Certification Form for Admission

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A). Currently the Bureau of the Fiscal Service within the Department of the Treasury is soliciting comments concerning the Minority Bank Deposit Program (MBDP) Certification Form for Admission.

DATES: Written comments should be received on or before May 9, 2016 to be assured of consideration.

ADDRESSES: Direct all written comments and requests for further information to Bureau of the Fiscal Service, Bruce A. Sharp, 200 Third Street A4–A, Parkersburg, WV 26106–1328, or *bruce.sharp@fiscal.treasury.gov.*

SUPPLEMENTARY INFORMATION:

Title: Minority Bank Deposit Program (MBDP) Certification Form for Admission.

OMB Number: 1530–0001 (Previously approved as 1510–0048 as a collection conducted by Department of the Treasury/Financial Management Service).

Transfer of OMB Control Number: Financial Management Service (FMS) and the Bureau of Public Debt (BPD) have consolidated to become the Bureau of the Fiscal Service (Fiscal Service). Information collection requests previously held separately by FMS and BPD will now be identified by a 1530 prefix, designating Fiscal Service.

Form Numbers: FS Form 3144.

Abstract: The information collected on this form is used by financial institutions to apply for participation in the Minority Bank Deposit Program. Institutions approved for acceptance in the program are entitled to special assistance and guidance from Federal agencies, State and local governments, and private sector organizations.

Current Actions: Extension of a previously approved collection.

Type of Review: Emergency.

Affected Public: Private Sector.

Estimated Number of Respondents: 150.

Estimated Time per Respondent: 30 minutes.

Estimated Total Annual Burden Hours: 75.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Dated: March 2, 2016.

Bruce A. Sharp,

Bureau Clearance Officer.

[FR Doc. 2016–05036 Filed 3–7–16; 8:45 am]

BILLING CODE 4810–AS–P

DEPARTMENT OF THE TREASURY

Bureau of the Fiscal Service

Proposed Collection of Information: Request To Reissue U.S. Savings Bonds to a Personal Trust

AGENCY: Bureau of the Fiscal Service, Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A). Currently the Bureau of the Fiscal Service within the Department of the Treasury is soliciting comments concerning the Request to Reissue U.S. Savings Bonds to a Personal Trust.

DATES: Written comments should be received on or before May 9, 2016 to be assured of consideration.

ADDRESSES: Direct all written comments and requests for further information to Bureau of the Fiscal Service, Bruce A. Sharp, 200 Third Street A4–A, Parkersburg, WV 26106–1328, or *bruce.sharp@fiscal.treasury.gov.*

SUPPLEMENTARY INFORMATION: *Title:* Request to Reissue U.S. Savings Bonds to a Personal Trust.

OMB Number: 1530–0036 (Previously approved as 1535–0009 as a collection conducted by Department of the Treasury/Bureau of the Public Debt.)

Transfer of OMB Control Number: The Bureau of Public Debt (BPD) and the Financial Management Service (FMS) have consolidated to become the Bureau of the Fiscal Service (Fiscal Service). Information collection requests previously held separately by BPD and FMS will now be identified by a 1530 prefix, designating Fiscal Service.

Form Number: FS Form 1851.

Abstract: The information is necessary to support a request for reissue of savings bonds in the name of the trustee of a personal trust estate.

Current Actions: Extension of a previously approved collection.

Type of Review: Emergency.

Affected Public: Households and Individuals.

Estimated Number of Respondents: 18,000.

Estimated Time per Respondent: 15 minutes.

Estimated Total Annual Burden Hours: 4,500.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital

or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Dated: March 2, 2016.

Bruce A. Sharp,

Bureau Clearance Officer.

[FR Doc. 2016–05037 Filed 3–7–16; 8:45 am]

BILLING CODE 4810–AS–P

DEPARTMENT OF THE TREASURY

Bureau of the Fiscal Service

Proposed Collection of Information: Application by Survivors for Payment of Bond or Check Issued Under the Armed Forces Leave Act of 1946, as Amended

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A). Currently the Bureau of the Fiscal Service within the Department of the Treasury is soliciting comments concerning the Application By Survivors for Payment of Bond or Check Issued Under the Armed Forces Leave Act of 1946, as amended.

DATES: Written comments should be received on or before May 9, 2016 to be assured of consideration.May 9, 2016

ADDRESSES: Direct all written comments and requests for further information to Bureau of the Fiscal Service, Bruce A. Sharp, 200 Third Street A4–A, Parkersburg, WV 26106–1328, or *bruce.sharp@fiscal.treasury.gov.*

SUPPLEMENTARY INFORMATION:

Title: Application by Survivors for Payment of Bond or Check Issued Under the Armed Forces Leave Act of 1946, as amended.

OMB Number: 1530–0038 (Previously approved as 1535–0104 as a collection conducted by Department of the Treasury/Bureau of the Public Debt.) Transfer of OMB Control Number: The Bureau of Public Debt (BPD) and the Financial Management Service (FMS) have consolidated to become the Bureau of the Fiscal Service (Fiscal Service). Information collection requests previously held separately by BPD and FMS will now be identified by a 1530 prefix, designating Fiscal Service.

Form Number: FS Form 2066.

Abstract: The information is requested to support payment of an Armed Forces Leave Bond or check issued under Section 6 of the Armed Forces Leave Act of 1946, as amended, where the owner died without assigning the bond to the Administrator of Veterans Affairs prior to payment, or without presenting the check for payment.

Current Actions: Extension of a previously approved collection.

Type of Review: Emergency.

Affected Public: Households and Individuals.

Estimated Number of Respondents: 2,500.

Estimated Time per Respondent: 30 minutes.

Estimated Total Annual Burden Hours: 1,250.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Dated: March 2, 2016.

Bruce A. Sharp,

Bureau Clearance Officer.

[FR Doc. 2016–05038 Filed 3–7–16; 8:45 am]

BILLING CODE 4810–AS–P

DEPARTMENT OF VETERANS AFFAIRS

Commission on Care

ACTION: Notice of meeting.

In accordance with the Federal Advisory Committee Act, 5 U.S.C., App. 2, the Commission on Care gives notice that it will meet on Monday, March 21, 2016; Tuesday, March 22, 2016, and Wednesday, March 23, 2016, at the 20 F Street NW., Conference Center located at 20 F Street NW., Washington, DC 20001. On Monday, March 21, the meeting will convene at 1:00 p.m. (EST) and end by 5:00 p.m. (EST). On March 22 and March 23, the meetings will convene at 8:30 a.m. (EST) and end by 5:00 p.m. (EST). The meetings are open to the public. A telephone conference line will be available for a limited number of remote attendees to observe meeting deliberations.

The purpose of the Commission, as described in section 202 of the Veterans Access, Choice, and Accountability Act of 2014, is to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the next 20 years.

No time will be allocated at this meeting for receiving oral presentations from the public. The public may submit written statements for the Commission's review to *commissiononcare@va.gov.* Any member of the public wishing to attend may register their intentions by emailing the Designated Federal Officer, John Goodrich, at *commissiononcare@va.gov.* Remote attendees joining by telephone must email Mr. Goodrich by 12:00 p.m. (EST) on Friday, March 18, 2016, to request dial-in information.

Dated: March 3, 2016.

John Goodrich,

Designated Federal Officer, Commission on Care.

[FR Doc. 2016–05103 Filed 3–7–16; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0741]

Proposed Information Collection (Report of Subcontracts to Small and Veteran-Owned Business—VA0896a) Activity: Comment Request

AGENCY: Office of Small and Disadvantaged Business Utilization (OSDBU), the Department of Veterans Affairs (VA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501–3521), this notice announces that OSDBU, Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before April 7, 2016.

ADDRESSES: Submit written comments on the collection of information through *www.Regulations.gov,* or to Office of Information and Regulatory Affairs, Office of Management and Budget, Attn: VA Desk Officer; 725 17th St. NW., Washington, DC 20503 or sent through electronic mail to *oira_submission@omb.eop.gov.* Please refer to ''OMB Control No. 2900–0741 (VA0896a)'' in any correspondence.

FOR FURTHER INFORMATION CONTACT: Crystal Rennie, Enterprise Records Service (005R1B), Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 632–7492 or email *crystal.rennie@va.gov.* Please refer to ''OMB Control No. 2900–0741 (VA0896a)''.

SUPPLEMENTARY INFORMATION:

Title: Report of Subcontracts to Small and Veteran-Owned Business.

OMB Control Number: 2900–0741.

Type of Review: Revision of a currently approved collection.

Abstract: In accordance with Public Law 109–461, title V, section 502(a)(1), codified at 38 U.S.C. 8127(a)(4), the Office of Small and Disadvantaged Business Utilization (OSDBU) will use the VA Form 0896a to collect information from subcontractors to compare information obtained from subcontracting plans submitted by prime contractors in order to determine the accuracy of the data reported by prime contractors. The form has been modified to allow the collection of information from multiple subcontractors in the same form.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published at 80 FRN 76743 on December 10, 2015.

Affected Public: VA Prime Contractors.

Estimated Annual Burden: 610 hours.

Estimated Average Burden per Respondent: 2 hours.

Frequency of Response: Once a year.

Estimated Number of Respondents: 305.

By direction of the Secretary:

Kathleen M. Manwell,

Program Analyst, VA Privacy Service, Office of Privacy and Records Management, Department of Veterans Affairs.

[FR Doc. 2016–05009 Filed 3–7–16; 8:45 am]

BILLING CODE 8320–01–P

FEDERAL REGISTER

Vol. 81 Tuesday,
No. 45 March 8, 2016

Part II

Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 153, 154, 155, 156, and 158

[CMS–9937–F]

RIN 0938–AS57

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional amendments regarding the annual open enrollment period for the individual market for the 2017 and 2018 benefit years; essential health benefits; cost sharing; qualified health plans; Exchange consumer assistance programs; network adequacy; patient safety; the Small Business Health Options Program; stand-alone dental plans; third-party payments to qualified health plans; the definitions of large employer and small employer; fair health insurance premiums; student health insurance coverage; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions and appeals; and other related topics.

DATES: These regulations are effective on May 9, 2016.

FOR FURTHER INFORMATION CONTACT: Jeff Wu, (301) 492–4305, Krutika Amin, (301) 492–5153, or Lindsey Murtagh (301) 492–4106, for general information.

David Mlawsky, (410) 786–6851, for matters related to fair health insurance premiums, student health insurance coverage, and the single risk pool.

Kelly Drury, (410) 786–0558, for matters related to risk adjustment.

Adrianne Glasgow, (410) 786–0686, for matters related to reinsurance, distributed data collection, and administrative appeals of financial transfers.

Melissa Jaffe, (301) 492–4129, for matters related to risk corridors.

Lisa Cuozzo, (410) 786–1746, for matters related to rate review.

Jennifer Stolbach, (301) 492–4350, for matters related to establishing a State Exchange, and State-based Exchanges on the Federal Platform.

Emily Ames, (301) 492–4246, and Michelle Koltov, (301) 492–4225, for matters related to Navigators, non-Navigator assistance personnel, and certified application counselors under part 155.

Briana Levine, (301) 492–4247, for matters related to agents and brokers.

Dana Krohn, (301) 492–4412, for matters related to employer notification and verification.

Rachel Arguello, (301) 492–4263, for matters related to open enrollment periods and special enrollment periods under part 155.

Anne Pesto, (410) 786–3492, for matters related to eligibility determinations and appeals of eligibility determinations for Exchange participation and insurance affordability programs, and eligibility determinations for exemptions.

Kate Ficke, (301) 492–4256, for matters related to exemptions from the shared responsibility payment.

Ryan Mooney, (301) 492–4405, for matters related to enrollment.

Terence Kane, (301) 492–4449, for matters related to the income threshold.

Christelle Jang, (410) 786–8438, for matters related to the SHOP.

Krutika Amin, (301) 492–5153, for matters related to the Federally-facilitated Exchange user fee.

Leigha Basini, (301) 492–4380, for matters related to essential health benefits, network adequacy, essential community providers, and other standards for QHP issuers.

Ielnaz Kashefipour, (301) 492–4376, for matters related to standardized options and third party payment of premiums and cost sharing.

Rebecca Zimmermann, (301) 492–4396, for matters related to stand-alone dental plans.

Cindy Chiou, (301) 492–5142, for matters related to QHP issuer oversight.

Pat Meisol, (410) 786–1917, for matters related to cost-sharing reductions and the premium adjustment percentage.

Nidhi Singh Shah, (301) 492–5110, for matters related to patient safety standards.

Christina Whitefield, (301) 492–4172, for matters related to the medical loss ratio program.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Executive Summary
II. Background
A. Legislative and Regulatory Overview
B. Stakeholder Consultation and Input
C. Structure of Final Rule
III. Provisions of the Final Regulations and Analyses and Responses to Public Comments
A. Part 144—Requirements Relating to Health Insurance Coverage
B. Part 146—Requirements for the Group Health Insurance Market
C. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets
D. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act
E. Part 154—Health Insurance Issuer Rate Increases: Disclosure and Review Requirements
F. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act
G. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges
H. Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements
IV. Collection of Information Requirements
A. ICRs Regarding Student Health Insurance Coverage
B. ICRs Regarding Submission of Risk Corridors Data
C. ICRs Regarding Submission of Rate Filing Justification
D. ICRs Regarding Election to Operate an Exchange after 2014
E. ICRs Regarding Standards for Certified Application Counselors
F. ICRs Regarding Network Adequacy Standards
G. ICR Regarding Monthly SHOP Enrollment Reconciliation Files Submitted by Issuers
H. ICR Regarding Patient Safety Standards
I. ICRs Regarding Other Notices
V. Regulatory Impact Analysis
A. Statement of Need
B. Overall Impact
C. Impact Estimates of the Payment Notice Provisions and Accounting Table
D. Regulatory Alternatives Considered
E. Regulatory Flexibility Act
F. Unfunded Mandates
G. Federalism
H. Congressional Review Act

Acronyms and Abbreviations

Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended
AHRQ Agency for Healthcare Research and Quality
APTC Advance payments of the premium tax credit
AV Actuarial value
BBEDCA Balanced Budget and Emergency Deficit Control Act of 1985
CCN CMS Certification Number
CFR Code of Federal Regulations
CHIP Children's Health Insurance Program
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CSR Cost-sharing reduction
ECN Exemption certificate number
ECP Essential community provider
EHB Essential health benefits
FFE Federally-facilitated Exchange
FF–SHOP Federally-facilitated Small Business Health Options Program

FPL Federal poverty level
FR Federal Register
FTE Full-time equivalent
GDP Gross domestic product
HCC Hierarchical condition category
HEN Hospital engagement network
HHS United States Department of Health and Human Services
HICS Health Insurance Casework System
HIOS Health Insurance Oversight System
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HRSA Health Resources and Services Administration
HSA Health Savings Account
IRS Internal Revenue Service
MAGI Modified adjusted gross income
MAT Medication assisted treatment
MLR Medical loss ratio
MV Minimum value
NAIC National Association of Insurance Commissioners
NHEA National Health Expenditure Accounts
OMB Office of Management and Budget
OPM United States Office of Personnel Management
PBM Prescription benefit manager
PHS Act Public Health Service Act
PII Personally identifiable information
PMPM Per member per month
PRA Paperwork Reduction Act of 1995
PSO Patient safety organization
PSQIA Patient Safety and Quality Improvement Act (Pub. L. 109–41)
QHP Qualified health plan
QIO Quality improvement organizations
RADV Risk adjustment data validation
SADP Stand-alone dental plan
SBC Summary of benefits and coverage
SBE State-based Exchange
SBE–FP State-based Exchange on the Federal platform
SHOP Small Business Health Options Program
The Code Internal Revenue Code of 1986 (26 U.S.C. 1, *et seq.*)

I. Executive Summary

The Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended (the Affordable Care Act) enacted a set of reforms that are making high-quality health insurance coverage and care more affordable and accessible to millions of Americans. These reforms include the creation of competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges'' (in this final rule, we also call an Exchange a Health Insurance Marketplace℠,[1] or Marketplace℠) through which qualified individuals and qualified employers can purchase health insurance coverage. In addition, many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit to make health insurance more affordable, and reductions in cost-sharing payments to reduce out-of-pocket expenses for health care services. These Affordable Care Act reforms also include the premium stabilization programs (risk adjustment, reinsurance and risk corridors) and rules that mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. In previous rulemaking, we have outlined the major provisions and parameters related to many Affordable Care Act programs.

In this rule, we seek to improve States' ability to operate efficient Exchanges by leveraging the economies of scale available through the Federal eligibility and enrollment platform and information technology infrastructure. We are finalizing a codification of a new Exchange model—the State-based Exchange using the Federal platform (SBE–FP). This Exchange model will enable State-based Exchanges (SBEs) to execute certain processes using the Federal eligibility enrollment infrastructure. The SBE–FP will be required to enter into a Federal platform agreement with HHS that will define a set of mutual obligations, including the set of Federal services upon which the SBE–FP agrees to rely. Under this Exchange model, certain requirements that were previously only applicable to QHPs offered on a Federally-facilitated Exchange (FFE) and their downstream and delegated entities will apply to QHPs offered on an SBE–FP and their downstream and delegated entities. For 2017, we are finalizing a mechanism through which SBE–FPs will offset some of the Federal costs of providing this infrastructure. In addition, we are finalizing rules requiring agents and brokers facilitating enrollments through SBE–FPs to comply with the FFE registration and training requirements.

We are also finalizing a number of amendments that will improve the stability of the Exchanges and support consumers' ability to make informed choices when purchasing health insurance. These include the introduction of ''standardized options'' in the individual market FFEs. Additional amendments will increase the accessibility of high-quality health insurance and improve competition, transparency, and affordability.

Our intent in offering standardized options is to simplify the consumer shopping experience and to allow consumers to more easily compare plans across issuers in the individual market FFEs. We are finalizing a standardized option with a specified cost-sharing structure at each of the bronze, silver (with cost-sharing reduction (CSR) plan variations), and gold metal levels. This policy does not restrict issuers' ability to offer non-standardized options. We anticipate differentially displaying these standardized options to allow consumers to compare plans based on differences in price and quality rather than cost-sharing structures.

We are also finalizing policies relating to network adequacy for QHPs on the FFEs. We proposed, but are not finalizing, a minimum quantitative network adequacy threshold for each State. As States continue their work to implement the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act (NAIC Network Adequacy Model Act), we will continue to use the same quantitative time-distance standards in our review of plans for QHP certification on the FFEs, which we will detail in the annual Letter to Issuers, which we are issuing in final form concurrently with this final rule. We are finalizing our proposed policy regarding standardized categorization of network breadth for QHPs on the FFEs on HealthCare.gov. We are also finalizing two provisions to address provider transitions in the FFE and a standard for all QHPs governing cost sharing that would apply in certain circumstances when an enrollee receives essential health benefit (EHB) provided by an out-of-network ancillary provider at an in-network setting.

We discuss the authority for FFEs to continue to select QHPs based on meeting the interests of qualified individuals and qualified employers. We will use this authority to strengthen oversight as needed in the short term.

We also seek to improve consumers' ability to make choices regarding health insurance coverage by ensuring they receive high-quality assistance in their interactions with the Exchange. For example, this final rule amends program requirements for Navigators, certain non-Navigator assistance personnel, and certified application counselors. These amendments will require FFE Navigators to assist consumers with certain post-enrollment and other issues beginning in 2018, require all Navigators to provide targeted assistance to underserved or vulnerable populations, and require Navigators and non-Navigator assistance personnel to complete training prior to conducting outreach and education activities. We are also amending our rules regarding the giving of gifts by Navigators, certain non-Navigator assistance personnel, and certified application counselors. In

[1] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.

addition, we are finalizing our proposal that certified application counselor designated organizations will be required to submit data and information related to the organization's certified application counselors, upon the request of the Exchanges in which they operate.

In addition, this final rule takes several steps to increase transparency. This rule finalizes provisions to enhance the transparency of rates in all States and the effectiveness of the rate review program.

This rule also establishes dates for the individual market annual open enrollment period for future benefit years. For 2017 and 2018, we will maintain the same open enrollment period we adopted for 2016—that is, November 1 of the year preceding the benefit year through January 31 of the benefit year, and for 2019 and later benefit years, we are establishing an open enrollment period of November 1 through December 15 of the year preceding the benefit year. The rule also finalizes two narrow changes to the Exchange re-enrollment hierarchy, prioritizing re-enrollment into silver plans, and providing Exchanges with the flexibility to re-enroll consumers into plans of other Exchange issuers if the consumer is enrolled in a plan from an issuer that does not have another plan available for re-enrollment through the Exchange.

We summarize input we have received on whether special enrollment periods are being appropriately provided, and discuss our plans to conduct an assessment of special enrollment periods granted to consumers through the FFEs. We are also codifying a number of Exchange policies relating to exemptions in order to provide certainty and transparency around these policies for all stakeholders.

We are finalizing our proposals for the risk adjustment program—in particular, we are finalizing our introduction of preventive services into the methodology, and our calculation of model coefficients based on the 2012, 2013, and 2014 MarketScan claims data. This final rule also amends the risk corridors provisions related to the reporting of allowable costs.

In addition to provisions aimed at stabilizing premiums, we are finalizing several provisions related to cost sharing. First, we are finalizing the premium adjustment percentage for 2017, which is used to set the rate of increase for several parameters detailed in the Affordable Care Act, including the maximum annual limitation on cost sharing for 2017. We are also finalizing the maximum annual limitations on cost sharing for the 2017 benefit year for cost-sharing reduction plan variations. We also finalize standards for stand-alone dental plans (SADPs) related to the annual limitation on cost sharing, and standards related to third party payments for premiums and cost sharing made on behalf of enrollees by Federal, State, and local governments; Ryan White HIV/AIDS programs; and Indian tribes, tribal organizations, or urban Indian organizations.

We finalize several improvements that seek to ensure consumers have access to affordable, high-quality health care coverage. We are amending requirements for QHPs, including essential community providers (ECPs) and meaningful difference requirements. This rule also contains technical amendments to QHP issuer oversight provisions. This rule includes amendments to further strengthen the patient safety requirements for QHP issuers offering coverage through Exchanges.

For consumers purchasing coverage through the Small Business Health Options Program (SHOP), we finalize a new ''vertical choice'' model for Federally-facilitated SHOPs for plan years beginning on or after January 1, 2017, under which employers would be able to offer qualified employees a choice of all plans across all available actuarial value levels of coverage from a single issuer. States with a Federally-facilitated Small Business Health Options Program (FF–SHOP) will have the opportunity to recommend that vertical choice not be implemented in their State, and SBEs relying on the FF–SHOP eligibility and enrollment platform will be able to choose not to have vertical choice implemented in their State.

We also finalize adjustments to our programs and rules, as we do each year, so that our rules and policies reflect the latest market developments. We finalize the following changes and clarifications to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Affordable Care Act health insurance reform requirements. We revise the definitions of small employer and large employer to bring them into conformance with the Protecting Affordable Coverage for Employees Act (Pub. L. 114–60). We also finalize provisions to ensure that a network plan in the small group market with a limited service area can be appropriately rated for sale based on geography. Lastly, we finalize some of the proposed provisions regarding the application of the actuarial value (AV) and single risk pool provisions to student health insurance coverage.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the Affordable Care Act.

Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 2701 of the PHS Act, as added by the Affordable Care Act, restricts the variation in premium rates charged by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market to certain specified factors. The factors are: Family size, rating area, age, and tobacco use.

Section 2701 of the PHS Act operates in coordination with section 1312(c) of the Affordable Care Act. Section 1312(c) of the Affordable Care Act generally requires a health insurance issuer to consider all enrollees in all health plans (except for grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. States have the option to merge the individual market and small group market risk pools under section 1312(c)(3) of the Affordable Care Act.

Section 2702 of the PHS Act, as added by the Affordable Care Act, requires health insurance issuers that offer health insurance coverage in the group or individual market in a State to offer coverage to and accept every employer and individual in the State that applies for such coverage unless an exception applies.[2]

Section 2703 of the PHS Act, as added by the Affordable Care Act, and sections 2712 and 2741 of the PHS Act, as added by HIPAA and codified prior to the enactment of the Affordable Care Act, require health insurance issuers that offer health insurance coverage in the group or individual market to renew or

[2] Before enactment of the Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 amended the PHS Act (formerly section 2711) to generally require guaranteed availability of coverage for employers in the small group market.

continue in force such coverage at the option of the plan sponsor or individual unless an exception applies.

Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance issuers to submit an annual medical loss ratio (MLR) report to HHS, and provide rebates to enrollees if the issuers do not achieve specified MLR thresholds.

Section 2794 of the PHS Act, as added by the Affordable Care Act, directs the Secretary of HHS (the Secretary), in conjunction with the States, to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage.[3] The law also requires health insurance issuers to submit to the Secretary and the applicable State justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794(b)(2) of the PHS Act further directs the Secretary, in conjunction with the States, to monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange beginning with plan years starting in 2014.

Section 1252 of the Affordable Care Act provides that any standard or requirement adopted by a State under title I of the Affordable Care Act, or any amendment made by title I of the Affordable Care Act, is to be applied uniformly to all health plans in each insurance market to which the standard and requirement apply.

Section 1302 of the Affordable Care Act provides for the establishment of an EHB package that includes coverage of EHB (as defined by the Secretary), cost-sharing limits, and actuarial value requirements. The law directs that EHBs be equal in scope to the benefits covered by a typical employer plan, and that they cover at least the following 10 general categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Section 1301(a)(1)(B) of the Affordable Care Act directs all issuers of QHPs to cover the EHB package described in section 1302(a) of the Affordable Care Act, including coverage of the services described in section 1302(b) of the Affordable Care Act, to adhere to the cost-sharing limits described in section 1302(c) of the Affordable Care Act, and to meet the AV levels established in section 1302(d) of the Affordable Care Act. Section 2707(a) of the PHS Act, which is effective for plan or policy years beginning on or after January 1, 2014, extends the coverage of the EHB package to non-grandfathered individual and small group coverage, irrespective of whether such coverage is offered through an Exchange. In addition, section 2707(b) of the PHS Act directs non-grandfathered group health plans to ensure that cost sharing under the plan does not exceed the limitations described in sections 1302(c)(1) and (2) of the Affordable Care Act.

Section 1302(d) of the Affordable Care Act describes the various levels of coverage based on actuarial value. Consistent with section 1302(d)(2)(A) of the Affordable Care Act, actuarial value is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the Affordable Care Act directs the Secretary to develop guidelines that allow for *de minimis* variation in AV calculations.

Section 1311(b)(1)(B) of the Affordable Care Act directs that the Small Business Health Options Program assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. Sections 1312(f)(1) and (2) of the Affordable Care Act define qualified individuals and qualified employers. Under section 1312(f)(2)(B) of the Affordable Care Act, beginning in 2017, States will have the option to allow issuers to offer QHPs in the large group market through an Exchange.[4]

Section 1311(c)(1)(B) of the Affordable Care Act requires the Secretary to establish minimum criteria for provider network adequacy that a health plan must meet to be certified as a QHP.

Section 1311(c)(5) of the Affordable Care Act requires the Secretary to continue to operate, maintain, and update the Internet portal developed under section 1103 of the Affordable Care Act to provide information to consumers and small businesses on affordable health insurance coverage options.

Section 1311(c)(6)(B) of the Affordable Care Act states that the Secretary is to set annual open enrollment periods for Exchanges for calendar years after the initial enrollment period.

Sections 1311(d)(4)(K) and 1311(i) of the Affordable Care Act direct all Exchanges to establish a Navigator program.

Section 1311(h)(1) of the Affordable Care Act specifies that a QHP may contract with health care providers and hospitals with more than 50 beds only if they meet certain patient safety standards, including use of a patient safety evaluation system, a comprehensive hospital discharge program, and implementation of health care quality improvement activities. Section 1311(h)(2) of the Affordable Care Act also provides the Secretary flexibility to establish reasonable exceptions to these patient safety requirements and section 1311(h)(3) of the Affordable Care Act allows the Secretary flexibility to issue regulations to modify the number of beds described in section 1311(h)(1)(A) of the Affordable Care Act.

Section 1312(a)(2) of the Affordable Care Act provides that in a SHOP, a qualified employer may select any level of coverage under section 1302(d) of the Affordable Care Act to be made available to employees through the SHOP, and that employees may then, in turn, choose plans within the level selected by the qualified employer.

Section 1321(a) of the Affordable Care Act provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the Affordable Care Act. Section 1321(a)(1) directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act with respect to, among other things, the establishment and operation of Exchanges.

Sections 1313 and 1321 of the Affordable Care Act provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1321 of the Affordable Care Act provides for State flexibility in the operation and enforcement of Exchanges and related requirements.

When operating an FFE under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections

[3] The implementing regulations in part 154 limit the scope of the requirements under section 2794 of the PHS Act to health insurance issuers offering health insurance coverage in the individual market or small group market. *See* Rate Increase Disclosure and Review; Final Rule, 76 FR 29964, 29966 (May 23, 2011).

[4] If a State elects this option, the rating rules in section 2701 of the PHS Act and its implementing regulations will apply to all coverage offered in such State's large group market (except for self-insured group health plans) under section 2701(a)(5) of the PHS Act.

1321(c)(1) and 1311(d)(5)(A) of the Affordable Care Act to collect and spend user fees. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. Office of Management and Budget (OMB) Circular A–25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the PHS Act. Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Part A of title XXVII of the PHS Act when a State fails to substantially enforce these provisions.

Section 1321(d) of the Affordable Care Act provides that nothing in title I of the Affordable Care Act should be construed to preempt any State law that does not prevent the application of title I of the Affordable Care Act. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations issued by the Secretary.

Section 1341 of the Affordable Care Act requires the establishment of a transitional reinsurance program in each State to help pay the cost of treating high-cost enrollees in the individual market in benefit years 2014 through 2016. Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that reduces the impact of inaccurate rate setting from 2014 through 2016. Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program to provide payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, funded by payments from those that attract lower-risk populations, thereby reducing incentives for issuers to avoid higher-risk enrollees.

Sections 1402 and 1412 of the Affordable Care Act provide for, among other things, reductions in cost sharing for EHB for qualified low- and moderate-income enrollees in silver level health plans offered through the individual market Exchanges.

Section 5000A of the Internal Revenue Code of 1986 (the Code), as added by section 1501(b) of the Affordable Care Act, requires all non-exempt individuals to maintain minimum essential coverage for each month or make the individual shared responsibility payment. Section 5000A(f) of the Code defines minimum essential coverage as any of the following: (1) Coverage under a specified government sponsored program; (2) coverage under an eligible employer-sponsored plan; (3) coverage under a health plan offered in the individual market within a State; and (4) coverage under a grandfathered health plan. Section 5000A(f)(1)(E) of the Code authorizes the Secretary of HHS, in coordination with the Secretary of the Treasury, to designate other health benefits coverage as minimum essential coverage.

The Protecting Affordable Coverage for Employees Act amended section 1304(b) of the Patient Protection and Affordable Care Act and section 2791(e) of the PHS Act to amend the definition of small employer in these statutes to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. It also amended these statutes to make conforming changes to the definition of large employer, and to provide that a State may treat as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

1. Premium Stabilization Programs

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the premium stabilization programs. We implemented the premium stabilization programs in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the benefit and payment parameters for the 2014 benefit year to expand the provisions related to the premium stabilization programs and set forth payment parameters in those programs (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409).

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the benefit and payment parameters for the 2015 benefit year to expand the provisions related to the premium stabilization programs, setting forth certain oversight provisions and establishing the payment parameters in those programs (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743).

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the benefit and payment parameters for the 2016 benefit year to expand the provisions related to the premium stabilization programs, setting forth certain oversight provisions and establishing the payment parameters in those programs (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

2. Program Integrity

In the June 19, 2013 **Federal Register** (78 FR 37031), we published a proposed rule that proposed certain program integrity standards related to Exchanges and the premium stabilization programs (proposed Program Integrity Rule). The provisions of that proposed rule were finalized in two rules, the ''first Program Integrity Rule'' published in the August 30, 2013 **Federal Register** (78 FR 54069) and the ''second Program Integrity Rule'' published in the October 30, 2013 **Federal Register** (78 FR 65045).

3. Exchanges

We published a request for comment relating to Exchanges in the August 3, 2010 **Federal Register** (75 FR 45584). We issued initial guidance to States on Exchanges on November 18, 2010. We proposed a rule in the July 15, 2011 **Federal Register** (76 FR 41865) to implement components of the Exchanges, and a rule in the August 17, 2011 **Federal Register** (76 FR 51201) regarding Exchange functions in the individual market, eligibility determinations, and Exchange standards for employers. A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges was published in the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule).

We established standards for SHOP in the 2014 Payment Notice. We also set forth standards related to Exchange user fees in the 2014 Payment Notice. We established an adjustment to the FFE user fee in the Coverage of Certain Preventive Services Under the Affordable Care Act final rule, published in the July 2, 2013 **Federal**

Register (78 FR 39869) (Preventive Services Rule).

In a final rule published in the July 17, 2013 **Federal Register** (78 FR 42823), we established standards for Navigators and non-Navigator assistance personnel in FFEs and for non-Navigator assistance personnel funded through an Exchange establishment grant. This final rule also established a certified application counselor program for Exchanges and set standards for that program.

4. Essential Health Benefits and Actuarial Value

On December 16, 2011, HHS released a bulletin [5] (the EHB Bulletin) that outlined an intended regulatory approach for defining EHB, including a benchmark-based framework. HHS also published a bulletin that outlined its intended regulatory approach to calculations of AV on February 24, 2012.[6] A proposed rule relating to EHBs and AVs was published in the November 26, 2012 **Federal Register** (77 FR 70643). We established requirements relating to EHBs and AVs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the February 25, 2013 **Federal Register** (78 FR 12833) (EHB Rule).

5. Market Rules

A proposed rule relating to the 2014 health insurance market rules was published in the November 26, 2012 **Federal Register** (77 FR 70584). A final rule implementing the health insurance market rules was published in the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules).

A proposed rule relating to Exchanges and Insurance Market Standards for 2015 and Beyond was published in the March 21, 2014 **Federal Register** (79 FR 15808) (2015 Market Standards Proposed Rule). A final rule implementing the Exchange and Insurance Market Standards for 2015 and Beyond was published in the May 27, 2014 **Federal Register** (79 FR 30239) (2015 Market Standards Rule).

6. Rate Review

A proposed rule to establish the rate review program was published in the December 23, 2010 **Federal Register** (75 FR 81003). A final rule with comment period implementing the rate review program was published in the May 23, 2011 **Federal Register** (76 FR 29963) (Rate Review Rule). The provisions of the Rate Review Rule were amended in final rules published in the September 6, 2011 **Federal Register** (76 FR 54969), the February 27, 2013 **Federal Register** (78 FR 13405), the May 27, 2014 **Federal Register** (79 FR 30339), and the February 27, 2015 **Federal Register** (80 FR 10749).

7. Medical Loss Ratio

We published a request for comment on section 2718 of the PHS Act in the April 14, 2010 **Federal Register** (75 FR 19297), and published an interim final rule with a 60-day comment period relating to the MLR program on December 1, 2010 (75 FR 74863). A final rule with a 30-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76573). An interim final rule with a 60-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76595). A final rule was published in the **Federal Register** on May 16, 2012 (77 FR 28790).

B. Stakeholder Consultation and Input

HHS consulted stakeholders on the policies related to the operation of Exchanges, including the SHOP and the premium stabilization programs. We have held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives to gather public input. We consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners, regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. We considered all public input we received as we developed the policies in this final rule.

C. Structure of Final Rule

The regulations outlined in this final rule will be codified in 45 CFR parts 144, 147, 153, 154, 155, 156 and 158.

The regulations in part 144, consistent with recent legislation, revise the definitions of ''large employer'' and ''small employer.''

The regulations in part 147 clarify the definition of principal business address, and establish the appropriate rating area under specific circumstances, for purposes of geographic rating. They also address the treatment of student health insurance coverage with regard to the AV and single risk pool requirements.

The regulations in part 153 codify how HHS will evaluate the risk adjustment and reinsurance data submitted to an issuer's dedicated distributed data environment. This rule also includes the risk adjustment user fee for 2017 and outlines certain modifications to the HHS risk adjustment methodology. This rule clarifies reporting requirements for the risk adjustment, reinsurance, and risk corridors programs.

The regulations in part 154 outline certain modifications to enhance the transparency and effectiveness of the rate review program. We require the submission of a Unified Rate Review Template from all issuers offering single risk pool coverage in the individual and small group market, including coverage with rate decreases or unchanged rates, as well as rates for new plans. We also announce our intention to disclose all proposed rate increases for single risk pool coverage at a uniform time on the CMS Web site, including rates with increases of less than 10 percent. Finally, we reiterate the process for establishing the uniform timeline that proposed rate increases subject to review and all final rate increases (including those not subject to review) for single risk pool coverage must be posted at a uniform time by States with Effective Rate Review Programs.

The regulations in part 155 include clarifications related to the functions of an Exchange, and establish the individual market open enrollment period for the 2017 and 2018 benefit years. Certain proposals in part 155 are related to the eligibility and verification processes related to eligibility for insurance affordability programs. We also amend and clarify rules related to enrollment of qualified individuals into QHPs. We describe changes to the process of submitting certain exemption applications and options for State Exchanges to handle exemptions. The finalized regulations also provide for a Federal platform agreement through which a State Exchange may agree to rely on the FFE for certain functions as an SBE–FP. We also finalize various proposals related to the SHOPs. We amend the standards applicable to the consumer assistance functions performed by Navigators, non-Navigator assistance personnel, and certified application counselors. We also discuss our approach to QHP certification, and modify standards for FFE-registered agents and brokers and requirements for HHS-approved vendors of FFE training. Part 155 also includes clarification to

[5] Essential Health Benefits Bulletin. (Dec. 16, 2011), available at *https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.*

[6] Actuarial Value and Cost-Sharing Reductions Bulletin. (Feb. 24, 2012), available at *https://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf.*

the policy regarding additional State-required benefits.

The regulations in part 156 establish parameters related to cost sharing, including the premium adjustment percentage, the maximum annual limitation on cost sharing, and the reductions in the maximum annual limitation for cost-sharing plan variations for 2017. We amend the timeframe to request reconsideration under the administrative appeals process applicable to the premium stabilization programs. Amendments to part 156 also include provisions related to EHB prescription drug rules. We amend network adequacy requirements (including application of out-of-network costs to the annual limitation on cost sharing for EHBs covered under QHPs in the small group and individual markets), and essential community provider requirements. We establish standardized options for cost-sharing structures, indexing for the stand-alone dental plan annual limitation on cost sharing, changes to our process for updating the AV Calculator for QHPs, meaningful difference standards for QHPs, and minor changes to QHP issuer oversight standards. We also amend provisions related to the third-party premium payments from certain entities and the next phase of implementation for patient safety standards for issuers of QHPs offered on Exchanges.

The amendments to the regulations in part 158 finalize revisions related to the definitions of large employer and small employer consistent with recent legislation.

III. Provisions of the Final Regulations and Analyses and Responses to Public Comments

In the December 2, 2015 **Federal Register** (80 FR 75487), we published the ''Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017'' proposed rule. We received 524 comments, including 112 substantially similar letters regarding our solicitation for comment on whether the substance use disorder requirement in essential health benefits needs additional clarification regarding medication-assisted treatment for opioid addiction. Comments were received from the National Association of Insurance Commissioners, State departments of insurance, State Exchanges, a member of Congress, health insurance issuers, providers, consumer groups, labor entities, industry groups, patient safety groups, national interest groups, and other stakeholders. The comments ranged from general support of or opposition to the proposed provisions to specific questions or comments regarding proposed changes. We received a number of comments and suggestions that were outside the scope of the proposed rule that will not be addressed in this final rule.

In this final rule, we provide a summary of each proposed provision, a summary of those public comments received that directly related to proposals, our responses to them, and a description of the provisions we are finalizing.

Comment: We received a number of comments stating that the comment period was unreasonably short, making it difficult for stakeholders to provide in-depth analysis and input. Commenters urged HHS to provide a comment period of 60 days from the date of publication in the **Federal Register** for this and future HHS Notices of Benefit and Payment Parameters.

Response: The timeline for publication of this final rule accommodates issuer filing deadlines for the 2017 benefit year. A 60-day comment period would have delayed the publication of this final rule, and created significant challenges for States, Exchanges, issuers, and other entities in meeting deadlines related to implementing these rules.

Comment: We received a number of comments disapproving of the wide array of topics covered in the rule.

Response: Many of the programs covered by this final rule are closely linked. To simplify the regulatory process, facilitate public comment, and provide the information needed to meet statutory deadlines, we have elected to propose and finalize these regulatory provisions in one rule, as we have in years past.

Comment: A number of comments, many focused primarily on proposals related to network adequacy, urged HHS to allow States to continue their oversight of their insurance markets and defer to the NAIC for the development of important industry-wide, State-based standards.

Response: We aim to establish Federal oversight standards that complement State standards while meeting Federal obligations, including for qualified health plans on Federally-facilitated Exchanges. We will continue to coordinate closely with State authorities to address compliance issues, eliminate duplicative requirements or review, and to reduce the burden on stakeholders.

Comment: Several comments emphasized the importance of ensuring coverage is affordable to consumers, or expressed concern that coverage purchased through the Exchanges is not affordable.

Response: We appreciate the importance of ensuring coverage purchased through the Exchanges is affordable to consumers, and believe affordability is critical to the success of the Exchanges.

A. Part 144—Requirements Relating to Health Insurance Coverage

1. Definitions (§ 144.103)

Section 144.103 sets forth definitions of terms that are used throughout parts 146 through 150. In the proposed rule, we discussed the definition of ''plan year'' and proposed revisions to the definitions of small employer and large employer that would be consistent with recent legislation. We also proposed a technical correction in the definition of excepted benefits to cross reference the group market provisions in § 146.145(b) rather than § 146.145(c). We are finalizing these provisions as proposed.

a. Plan Year

In the preamble to the proposed rule (80 FR at 79495), we explained that we interpret the definition of plan year in § 144.103 with respect to both grandfathered and non-grandfathered group health plans to mean a period that is no longer than 12 months.

Comment: One commenter requested clarification that a plan year may be shorter than 12 months under certain circumstances.

Response: A plan year may be shorter than 12 months under certain circumstances, but a plan year may not be longer than 12 months.

b. Large Employer and Small Employer

We proposed to revise the regulatory definitions of large employer and small employer in §§ 144.103 and 155.20 consistent with section 1304(b) of the Affordable Care Act and section 2791(e) of the PHS Act, as amended by the Protecting Affordable Coverage for Employees Act. We also proposed to codify statutory language providing that in the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer or a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. We are finalizing these revisions as proposed.

Comment: Several commenters supported our proposed definitions of large employer and small employer, including the codification related to employers that were not in existence throughout the preceding calendar year.

Response: We are finalizing the revisions to the definitions of large

employer and small employer in §§ 144.103 and 155.20 as proposed.[7]

B. Part 146—Requirements for the Group Health Insurance Market

1. Guaranteed Availability of Coverage for Employers in the Small Group Market (§ 146.150)

For a discussion of the proposed amendment to § 146.150, please see the preamble to § 147.104.

C. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Fair Health Insurance Premiums (§ 147.102)

a. Principal Business Address

Under section 2701 of the PHS Act and regulations at § 147.102, the rating area for a small group plan is based on the group policyholder's principal business address. We proposed to amend § 147.102(a)(1)(ii) to provide that if the employer has registered an in-State principal business address with the State, that location is the principal business address. We noted that an in-State address registered solely for purposes of service of process would not be considered the employer's principal business address, unless it is a substantial worksite for the employer's business. If an in-State principal business address is not registered with the State or is only registered for purposes of service of process and is not a substantial worksite, we proposed that the employer would designate as its principal business address the business address within the State where the greatest number of employees work in the applicable State.

When a network plan offered in a State has a limited service area, we noted that this policy could result in an issuer having to make a plan available under the guaranteed availability rules to an employer—because the employer has an employee who lives, works, or resides in the service area—but not be able to apply a geographic rating factor under the current rule—because the issuer might not have established rates applicable to the location of the employer's principal business address outside the plan's service area.

We proposed to amend § 147.102 to provide for an additional principal business address to be identified within a plan's service area in these circumstances so that the plan can be appropriately rated for sale to the employer. In such instances, the additional principal business address would be the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year, or, if there is no such business address, an address within the service area selected by the employer that reasonably reflects where the greatest number of employees live or reside as of the beginning of the plan year.

As stated in the preamble to the proposed rule, SHOPs, including the FF–SHOPs, may use the address that was used to establish a qualified employer's eligibility for participation in the SHOP to determine the applicable geographic rating area when calculating premiums for participating employers. The intent of these proposals was to establish a uniform set of rules that can be applied as simply as possible, while allowing plans to be properly rated.

We are finalizing the provisions proposed in § 147.102 of the proposed rule without substantive modification. However, we are finalizing the regulatory text in a way that does not refer to a location where employees live or reside as a principal business address, as we believe doing so in the proposed regulatory text was confusing, and we are making additional minor edits for clarity. These are not substantive modifications, as the proposed rule and this final rule apply the same test to determine the policyholder's rating area with respect to a network plan in such a situation.

Comment: Several commenters supported our proposed definition of principal business address, and our approach for allowing an employer to identify an additional principal business address within the service area of a network plan. Two commenters suggested HHS should not modify the standards for geographic rating, suggesting that the proposed rule provides opportunities and incentives for small employers to select an address based upon factors other than the true business location of the employer. These commenters did not provide an alternative approach to allow plans to be rated in this circumstance.

Response: We have revised the proposed rule text such that it no longer refers to an employer selecting a location where employees live or reside as a principal business address. The rule instead provides that if an employer does not have a business location in the issuer's service area, but has employees who live or reside within the service area, the geographic rating area for purposes of the network plan is the rating area where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year. We believe these standards for identifying an applicable rating area within the issuer's service area will ensure that a network plan can be appropriately rated for sale to the employer consistent with guaranteed availability requirements.

Comment: One commenter suggested we define ''substantial worksite'' to determine when a business address registered solely for purposes of service of process would be considered the employer's principal business address for rating purposes.

Response: The final rule does not provide a specific definition of substantial worksite. We believe the term is sufficiently clear and will not cause confusion. Nevertheless, we will monitor the implementation of this policy in considering whether it is appropriate to clarify what constitutes a substantial worksite in the future.

Comment: One commenter requested that the FF–SHOP verify that an address entered by an employer is the official principal place of business. We also received a comment requesting that we modify the FF–SHOP application process to allow more than one account per State and thus, allow for more than one rating area for an employer.

Response: Under § 155.710(b)(3), one criterion for being a qualified employer eligible to purchase coverage through a SHOP is that the employer has its principal business address in the Exchange service area and offers coverage to all its full-time employees through that SHOP, or offers coverage to each eligible employee through the SHOP serving that employee's primary worksite. If we receive a report that incorrect or inaccurate information has been provided on an FF–SHOP application, we may investigate and take corrective action as needed. Further, as stated in the preamble to the proposed rule, due to operational limitations, the SHOPs, including the FF–SHOPs, may not be able to accommodate multiple principal business addresses within a State for premium calculation purposes. As a result, due to current operational limitations, when a single employer application is completed in a State with an FF–SHOP, plan availability and premium calculations will be based on the principal business address entered on the FF–SHOP employer application.

[7] This final rule has no effect on previously issued guidance by CMS clarifying that offices of the Members of Congress, as qualified employers, are eligible to participate in a SHOP regardless of the size requirements set forth in the definition of ''qualified employer'' in 45 CFR 155.20. See Members of Congress and Staff Accessing Coverage through Health Insurance Exchanges (Marketplaces) (Sept. 30, 2013), available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/members-of-congress-faq-9-30-2013.pdf.*

Comment: One commenter asked for clarification on the interaction between § 155.710(b)(3) (governing eligibility standards for SHOP) and § 147.102(a)(1)(ii) (governing geographic rating).

Response: If SHOPs, including the FF–SHOPs, have operational limitations that do not permit them to fully implement the policy described above, they may use the address that was used to establish a qualified employer's eligibility for participation in the SHOP to determine which plans are available to the employer, as well as the applicable geographic rating area when calculating premiums for participating employers.

b. Other Issues Related to Rating Areas

In the preamble to the proposed rule, we noted that we have observed wide variations in the size of rating areas in the various States. We identified a concern that this variation could lead to smaller rating areas with a high concentration of higher-risk groups, which potentially compromises the risk-spreading objective that the single risk pool requirement is intended to achieve. At the same time, States are the primary regulators of health insurance, and we believe it is important to recognize the unique needs of each State. We also recognize the consumer disruption that could result from changes to rating areas. Therefore, we sought comment on whether we should seek more uniformity in the size of rating areas or establish a minimum size for rating areas, and if so, how that should be achieved, consistent with the principle of flexibility for States.

We also recognized the inconsistency that can occur between an issuer's rating area and the service area of some of its network-based plans. We indicated that it could be beneficial for the rating area and the service area to generally be consistent and sought comment on whether and how to achieve this objective.

Comment: One commenter supported rating areas of a minimum size as a way to spread risk, and two others suggested applying a minimum number of residents per rating area or a minimum number that is no less than a specified percentage of residents in the non-metropolitan statistical areas of a State. Many commenters, however, stated their opposition to any further Federal regulation defining rating areas, stating that the States are best equipped to determine how rating areas are established. One commenter stated that our example that each rating area be a contiguous area would adversely affect service area strategies that identify non-contiguous areas with similar pricing and network dynamics that may warrant placing them in the same service area. One commenter stated that limiting the number of rating areas to the number of metropolitan statistical areas plus one would be arbitrary. One commenter stated that basing rating areas on the relative population of each area would require frequent changes in rating areas due to population shifts.

Many commenters also opposed aligning rating areas with service areas. One stated that such an alignment could cause issuers to leave an entire geographic area rather than attempt to establish contracts with providers in other parts of a rating area, due to additional costs associated with establishing a broader network. One commenter observed that rating areas are based on geographic differences in cost of care, while service areas are constructed to ensure that a network plan has providers that can serve enrollees in specific geographic locations. One commenter observed that aligning rating areas with service areas could result in a significant increase in the number of plans submitted for approval and rate review and Health Insurance Oversight System (HIOS) plan IDs.

Response: We are not making changes to these regulations in this final rule, and will consider these comments as we continue to study these issues.

c. Child Age Rating

Section 147.102(e) provides for a uniform age curve in each State. When a State does not specify an age curve, a Federal default uniform age curve will apply. We stated in the proposed rule that we are investigating the child age rating factor in the Federal uniform age curve, and seek to determine whether the default factor is appropriate, or fails to adequately differentiate the health risk of children of different ages. We sought comment and data on the most appropriate child age curve, and the policy reasons underlying any recommendation.

Comment: One commenter did not support a varying child age curve, believing that in the individual market, children may need more care at certain ages, so a fixed age rating factor that applies to all children should continue to apply. With regard to the current fixed factor, several commenters stated that the current default factor of 0.635 for children under age 21 may be set too low.

Several commenters supported a varying child age curve, and set forth specific age gradations. Two commenters stated that the child age curve should be increased by a set amount for plans with embedded pediatric dental benefits. One commenter stated that we should consider using data consistent with data used to calibrate risk adjustment to determine child age factors, while one commenter stated that the age calibration for children must be adjusted in the uniform age curve.

Response: We recognize that the child age band and factor may need to be updated to better reflect the health risk of children and intend to address child age rating in future rulemaking or guidance.

2. Guaranteed Availability of Coverage (§ 147.104)

a. Product Discontinuance and Market Withdrawal Exceptions to Guaranteed Availability

In the proposed rule, we expressed concern about whether it would be in consumers' or issuers' interest to require guaranteed availability of a product while the issuer is in the process of winding down operations with respect to that product or all its products in a market. Therefore, we proposed to codify an exception to the guaranteed availability requirements under § 147.104 when the exception to guaranteed renewability of coverage related to discontinuing a product or all coverage in the market applies. Specifically, we proposed that an issuer may deny coverage to new individuals or employers during the applicable 90-day or 180-day notice period when the issuer is discontinuing a product or exiting the market. We proposed that an issuer must apply the denial uniformly to all employers or individuals in the large group, small group, or individual market, as applicable, in the State consistent with applicable State law, and without regard to the claims experience or any health-status related factor relating to those individuals or employers and their employees (or their respective dependents). We proposed that this exception not relieve issuers of their obligations to existing policyholders, such as their obligation to enroll dependents under an applicable special enrollment period. We proposed parallel provisions under § 146.150 addressing guaranteed availability of coverage for employers in the small group market under the HIPAA rules.

We are not finalizing the provisions proposed in §§ 147.104 and 146.150 of the proposed rule. As noted in the proposed rule, the product discontinuance exception to the guaranteed renewability requirement in

§ 147.106(c) requires an issuer to provide notice in writing, in the form and manner specified by the Secretary, to each plan sponsor or individual, as applicable, (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued. The market withdrawal exception to the guaranteed renewability requirement in § 147.106(d) requires an issuer to provide notice in writing to the applicable State authority and to each plan sponsor or individual, as applicable (and to all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued. We therefore proposed to interpret the interaction between the guaranteed availability and these guaranteed renewability provisions to permit an issuer to deny enrollments during the applicable product discontinuance or market withdrawal notice period. However, with regard to situations where an issuer decides to discontinue a product, we are concerned that the proposed policy could have an impact on the issuer's risk pool and rating for its other products. While a market withdrawal does not have the same impact since all of the issuer's products in a market are being discontinued, we believe this interpretation of the interaction between the laws to provide for an exception to the guaranteed availability requirements would have to be applied consistently in both a product discontinuance and market withdrawal situation. Therefore, going forward, we will not interpret these statutes to recognize an exception to the guaranteed availability requirement in either scenario, and the issuer must continue to offer coverage to and accept every employer or individual in the State that applies for coverage under a product until such time that the product is discontinued.

Consistent with previous guidance, with regard to individuals who enroll in a product after the specified deadline for providing the applicable product discontinuance or market withdrawal notice and before the particular product or products are discontinued, HHS will consider an issuer to satisfy the requirement to provide notice if the issuer provides prominent and effective notice at the time of application or enrollment that the product will be discontinued, in any form and manner permitted by applicable law and regulations.[8]

b. Minimum Participation and Contribution Rules

In the proposed rule, we expressed concern that the use of minimum group participation and employer contribution rules to deny coverage in the small group market could result in some applicable large employers, as defined in section 4980H of the Code, not reasonably being able to offer coverage to their full-time employees (and their dependents) and therefore potentially being liable for an employer shared responsibility payment under section 4980H of the Code, particularly in States that elect to expand the small group market to include employers with up to 100 employees.

In recognition of this dynamic, we noted that a State electing to expand its small group market to include employers with up to 100 employees may opt, under its own authority, to prohibit an issuer from restricting the availability of small group coverage based on employer contribution or group participation rules. Alternatively, in cases where a State expands the definition of a small employer to include employers with up to 100 employees, we could amend the guaranteed availability regulations, with respect to small employers with 51–100 employees or with respect to all small employers altogether, to achieve this objective. We sought comment on such an approach.

Comment: Several commenters stated that we should retain the ability of issuers to limit, to November 15 to December 15 of each year, when issuers must sell a policy to a small employer that fails to meet the issuer's group participation or contribution rules. Some commenters stated that issuers should retain this ability even with respect to groups of 51–100 employees, as doing otherwise would have an adverse impact on risk pools. One commenter stated that if we eliminate the ability of issuers to apply minimum contribution and participation rules, we should at least exempt issuers from having to offer and renew coverage to employers that selectively offer insured and self-funded coverage simultaneously to separate classes of employees. Such employers, the commenter stated, leave issuers with the highest-risk individuals. One commenter stated that we should amend the guaranteed availability requirements so that any employer, regardless of size, that can document that it is subject to Code section 4980H, must be sold a policy anytime during the year. The commenter stated that we should consider this approach for the entire small group market as well.

Response: This final rule does not make any changes to the guaranteed availability requirements as they apply in connection with minimum participation or contribution rules. We note that States have flexibility to further restrict the use of minimum employer contribution or group participation rules as appropriate.

3. Guaranteed Renewability of Coverage (§ 147.106)

Title XXVII of the PHS Act includes several exceptions to its guaranteed renewability provisions, including when a group health plan sponsor has violated a material plan provision relating to employer contribution or group participation rules, provided applicable State law allows an exception to guaranteed renewability under such circumstances; and for coverage made available in the individual market, or small or large group market only through one or more bona fide associations, if the individual's or employer's membership in the association ceases. Although the Affordable Care Act removed from Title XXVII these exceptions as they applied to guaranteed availability, it did not do so with respect to guaranteed renewability. Therefore, as we pointed out in the preamble to the proposed rule, a large employer whose coverage is non-renewed for one of these reasons, and a small employer whose coverage is non-renewed due to membership ceasing in an association, could be seen to have a right to immediately purchase that same coverage (if available in the market) from that same issuer in accordance with guaranteed availability. In the preamble to the proposed rule, we suggested that this renders effectively meaningless these two exceptions to guaranteed renewability in these contexts, and we proposed to amend § 147.106 to remove these guaranteed renewability exceptions.

For the reasons discussed in greater detail below, the final rule does not remove the guaranteed renewability exceptions related to failure to satisfy minimum employer contribution or group participation rules, or loss of association membership, because we have determined upon further consideration these exceptions can

[8] CMS Insurance Standards Bulletin Series, Form and Manner of Notices when Discontinuing or Renewing a Product in the Group or Individual Market (Sept. 2, 2014), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.pdf.*

affect the insurance plan choices available to consumers and employers.

Comment: Two commenters suggested we should not remove the guaranteed renewability exceptions when a small employer's membership in an association ceases. The commenters stated that typically a blanket master policy is issued to the association and it would not be appropriate for small employers who leave the association to continue to receive coverage through the same policy.

Response: Based on the comments received and after further review and consideration of the statutory provisions, we have concluded that the guaranteed availability requirements do not render effectively meaningless the guaranteed renewability exceptions for loss of association membership or failure to meet group participation or contribution rules. For example, an employer with association coverage leaving the association mid-year and losing coverage may be subject to a different premium rate under a new policy based on a quarterly rate update in the small group market or a new experience rate in the large group market. Further, we recognize that association members who cease membership in an association and lose coverage may have their deductible and maximum out of pocket limit reset under a new policy. The same logic applies with respect to employers whose coverage is terminated mid-year for failure to meet an issuer's participation or contribution rules. And, small employers whose coverage is terminated for failure to meet minimum participation or contribution rules might not be able to purchase new coverage until the next annual enrollment period from November 15 to December 15. For these reasons, we believe these exceptions to guaranteed renewability continue to have relevance, and we are not finalizing our proposal to remove them from the regulations.

4. Student Health Insurance Coverage (§ 147.145)

a. Index Rate Setting Methodology for Student Health Insurance Coverage

Under § 147.145, student health insurance coverage is a type of individual health insurance coverage that, subject to certain limited exceptions, must comply with the PHS Act requirements that apply to individual health insurance coverage. However, section 1560(c) of the Affordable Care Act provides that nothing in title I of the Affordable Care Act (or an amendment made by title I) is to be construed to prohibit an institution of higher education from offering a student health insurance plan to the extent that the requirement is otherwise permitted under applicable Federal, State, or local law. HHS has exercised its authority under section 1560(c) of the Affordable Care Act to modify some of its rules as applied to student health insurance coverage, including those related to the guaranteed availability, guaranteed renewability, and single risk pool requirements.

As we stated in the preamble to the proposed rules, our intent in exempting student health insurance coverage from the single risk pool requirement was to provide that student health insurance issuers need not include their student health insurance coverage in their overall individual market (or merged market) risk pool, and also need not have one single risk pool composed of their total statewide book of student health insurance business. Rather, we intended that issuers could establish risk pools for students and their dependents separate from the issuer's individual market or merged market risk pool, including by establishing separate risk pools for different institutions of higher education, or multiple risk pools within a single institution. However, as explained in the preamble to the proposed rule, we have learned that student health insurance issuers may be using certain rating factors that lead to rates that might not be actuarially justified.

As stated in the preamble to the proposed rule, we do not intend to disrupt rate setting for student health insurance, but we do seek to ensure that rates are based on actuarially justified factors. To clarify our intent, we proposed, for policy years beginning on or after January 1, 2017, that student health insurance coverage be subject to the index rate setting methodology of the single risk pool provision in the regulation at § 156.80(d). However, student health insurance issuers still would be permitted to establish separate risk pools from their individual market single risk pool (or merged market risk pool, where applicable) for student health insurance coverage, including by establishing separate risk pools for different institutions of higher education, or multiple risk pools within a single institution, provided they are based on a bona fide school-related classification (for example, graduate students and undergraduate students) and not a health status-related factor as described in § 146.121. Consistent with our single risk pool policy, the index rates for these risk pools would be based upon actuarially justified estimates of claims. We proposed that permissible plan-level adjustments to these index rates would be limited to those permitted under our rules. This approach would continue to allow rates for student health insurance coverage to reflect the unique characteristics of the student population at the particular institution, while more clearly delineating our intent with regard to the treatment of student health insurance coverage. We sought comment on any potential operational challenges associated with this proposal, including potential challenges related to filing rates for student health insurance coverage and how this policy might be adjusted to address those challenges.

We finalize in this rule our proposal that student health insurance issuers may establish one or more risk pools per institution of higher education, provided that the risk pools are based on a bona fide school-related classification and not based on a health factor as described in § 146.121. In response to comments, we are not finalizing our proposal that student health insurance coverage must comply with the single risk pool index rate setting methodology. However, we are requiring that student health insurance rates reflect the claims experience of individuals who comprise the risk pool and any adjustments to rates within a risk pool must be based on actuarially justified factors. We are also removing outdated provisions in § 147.145(b)(2) and (d) providing that student health insurance issuers may impose annual dollar limits for policy years beginning before January 1, 2014. Those provisions, by their own terms, no longer apply, as student health insurance issuers are subject to the provisions in § 147.126 that prohibit annual dollar limits on EHB for policy years beginning on or after January 1, 2014. Accordingly, we are finalizing the AV provision proposed in paragraph (b)(4) at paragraph (b)(2), and deleting outdated paragraphs (d) and (e).

Comment: While one commenter supported the proposal to subject student health insurance issuers to the index rate setting methodology, several commenters were opposed to the proposal, citing concerns about additional administrative and regulatory burdens on both issuers and State regulators, as well as concerns about limiting consumer choice and flexibility and undermining the role of institutions of higher education in arranging for coverage that best meets the needs of their student populations.

Response: After carefully considering these comments, we have determined not to apply the single risk pool index

rate setting methodology to student health insurance coverage. While we continue to have concerns that student health insurance issuers may be setting rates that are not based upon actuarially justified estimates of claims, we are also mindful of the concerns about potential administrative burden. The single risk pool rate setting methodology is one means of ensuring rates are actuarially justified. Therefore, while student issuers will not be required to use that particular methodology to establish rates, the final rule requires that rates for student health insurance coverage reflect the claims experience of individuals who comprise the risk pool and any adjustments to rates within a risk pool must be actuarially justified. We intend to monitor whether factors are being used to develop rates for student health insurance coverage that are not actuarially justified, such as adjusting rates based upon the length of time the coverage has been underwritten by the issuer.

Comment: Several commenters supported our proposal to permit issuers to establish one or more risk pools per institution of higher education, provided the risk pools are based on a bona fide school-related classification and not a health factor as described in § 146.121. Two commenters urged us not to permit multiple risk pools within a single institution of higher education, expressing concern that subgroups could be discriminatory in nature. One commenter requested clarification that issuers may create risk pools comprised of more than one college or university.

Response: The final rule provides that student risk pools must be based on a bona fide school-related classification and not a health factor as defined in § 146.121. The risk pools may include enrollees at one or multiple institutions of higher educations in the State or nationally, or certain subgroups within a single institution of higher education, provided that the risk pools are based on a bona fide classification and not discriminatory based on health status. We believe these standards balance issuer flexibility with appropriate safeguards against potentially discriminatory risk pooling practices. We note that nothing prevents a State from requiring broader risk pooling with respect to student health insurance coverage than provided for in this final rule (for example, requiring each student health insurance issuer to establish one risk pool comprised of its entire student health insurance book of business).

Comment: Some commenters requested clarification that issuers may establish separate risk pools for students and dependents. Other commenters suggested that issuers should be permitted to apply actuarially justified rating factors to distinguish between students and their dependents who are on the same plan or cross-subsidize between students and dependents in order to keep premiums for dependent coverage affordable.

Response: Under this final rule, an issuer may create separate risk pools for students and dependents. Dependent rates may vary from those for students as long as dependents constitute a separate risk pool and are enrolled in separate coverage from students. However, consistent with the rating rules under section 2701 of the PHS Act, if students and dependents are enrolled in the same coverage, then rates may not vary based on student or dependent status, but may vary based on age and family size. Nothing in this final rule prevents an issuer from including students and dependents in the same risk pool.

b. Actuarial Value Requirements for Student Health Insurance Plans

As stated in the preamble to the proposed rule, many colleges and universities have reported to us that they offer student health insurance plans that are rich in benefits (for example, providing an actuarial value of 96 percent) and that they are reluctant to reduce the level of benefits to meet an actuarial value metal level. We stated that because enrollees in student health insurance plans are not typically selecting among such plans, there is less need for standardization of actuarial levels in this part of the individual market. Therefore, we proposed to add an exemption to the requirements for student health insurance coverage in § 147.145, under which, for plan years beginning on or after January 1, 2017, student health insurance coverage would be exempt from the actuarial value ''metal level'' requirements under section 1302(d) of the Affordable Care Act, as implemented in §§ 156.135 and 156.140, but would be required to provide an actuarial value of at least 60 percent. To determine a plan's actuarial value for purposes of the application of the 60 percent actuarial value requirement to student health insurance coverage, we proposed to require student health insurance coverage issuers to obtain certification by an actuary that the plan provides an actuarial value of at least 60 percent. This determination would be required to be made by a member of the American Academy of Actuaries, based on analysis in accordance with generally accepted actuarial principles and methodologies. We sought comment on this proposal, including whether to continue to require student health insurance issuers to determine the actuarial value of their coverages by using the actuarial value calculator, as currently required, instead of through actuarial certification.

We are finalizing our proposal to require student health insurance coverage to meet a minimum 60 percent actuarial value, as opposed to meeting any specific metal level. We are not finalizing our proposal that actuarial value would be determined by certification of an actuary but rather require that it be determined using the actuarial value calculator, as is the case for other individual market and small group market coverage. Requiring the actuarial value of student health insurance coverage to be calculated using the same methodology as those other types of coverage will allow students and their dependents to better compare the generosity of student health insurance with other available coverage options, such as coverage under a parent's plan or coverage through the Exchange. We also specify that this provision will apply for ''policy years'' beginning on or after July 1, 2016 as opposed to plan years beginning on or after January 1, 2017. The reference to ''policy years'' is the more appropriate term with regard to student health insurance coverage, a type of individual market coverage. We recognize that student health plans typically operate on a policy year that is not the calendar year, and therefore we have modified the provision to take effect beginning with coverage for the upcoming academic year as was our intent in the proposed rule.

Comment: Several commenters supported our proposal to require student health insurance plans to meet at least 60 percent actuarial value, instead of meeting any specific metal level. However, several commenters stated that student health insurance plans should be required to meet metal levels, for purposes of transparency and comparability with other plans.

Response: Although we are finalizing the 60 percent actuarial value proposal, we agree that it is important for enrollees and potential enrollees in student health insurance plans to be able to compare such plans with others for which they may be eligible, such as their parents' plan or an individual market non-student plan. In the proposed rule, we had solicited comments on whether to require student health insurance issuers to specify, in their summary of benefits and coverage

(SBC) documents, enrollment materials, marketing materials, or other materials, the actuarial value of the coverage, the next lowest metal level the coverage would otherwise satisfy, based on its actuarial value, or any other data that would give enrollees and prospective enrollees information about the actuarial value of the coverage. Several commenters supported this general approach. One opposed it, arguing that the actuarial value for student health insurance coverage is an unreliable indicator of the true value of the plan. However, we believe that disclosing the actuarial value of the coverage, and the next lowest metal level the coverage would otherwise satisfy, based on its actuarial value, would be a helpful tool. Therefore, we are finalizing a requirement that student health insurance issuers must disclose, in any plan materials summarizing the terms of the coverage, the actuarial value of the coverage and the metal level (or next lowest metal level) the coverage would satisfy. This requirement will not apply to the SBC, unless and until such information is incorporated into the SBC template and instructions.

Comment: One commenter recommended removing the 92 percent actuarial value cap on platinum level student plans instead of eliminating the metal level requirements altogether.

Response: We believe that the same reasons to give platinum plans flexibility with respect to actuarial value also apply to other metal level plans. Therefore, we are providing flexibility in this final rule for student health insurance plans to provide any AV at or above 60 percent.

D. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment Under the Affordable Care Act

In the proposed rule, we proposed a number of modifications to the risk adjustment, reinsurance, and risk corridors programs.

Comment: One commenter asked that HHS present all regulatory information related to the premium stabilization programs in a clear, transparent, reliable and timely manner. Another commenter asked that the risk adjustment and reinsurance data collection requirements be limited to data currently held by plans in order to not increase the administrative burden on providers.

Response: HHS is committed to providing regulations and guidance in a clear and timely manner, and seeks to minimize the administrative burden of our data collection.

1. Sequestration

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2016,[9] both the transitional reinsurance program and permanent risk adjustment program are subject to the fiscal year 2016 sequestration. The Federal government's 2016 fiscal year began on October 1, 2015. The reinsurance program will be sequestered at a rate of 6.8 percent for payments made from fiscal year 2016 resources (that is, funds collected during the 2016 fiscal year). To meet the sequestration requirement for the risk adjustment program for fiscal year 2016, HHS will sequester risk adjustment payments made using fiscal year 2016 resources in all States where HHS operates risk adjustment at a sequestration rate of 7.0 percent. HHS estimates that increasing the sequestration rate for all risk adjustment payments made in fiscal year 2016 to all issuers in the States where HHS operates risk adjustment by 0.2 percent will permit HHS to meet the required national risk adjustment program sequestration percentage of 6.8 percent noted in the OMB Report to Congress.

HHS, in coordination with OMB, has determined that, under section 256(k)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 (the BBEDCA), as amended, and the underlying authority for these programs, the funds that are sequestered in fiscal year 2016 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2017 without further Congressional action. If the Congress does not enact deficit reduction provisions that replace the Joint Committee reductions, these programs will be sequestered in future fiscal years, and any sequestered funding will become available in the fiscal year following the one in which it was sequestered.

Comment: One commenter stated that risk adjustment payments should not be subject to sequestration because the risk adjustment program is budget neutral and the Federal government is simply transferring funds among issuers.

Response: The BBEDCA requires all non-exempt budgetary resources be sequestered in amounts sufficient to achieve the savings targets established in the Budget Control Act of 2011. Risk adjustment payments are subject to sequestration as they are budgetary resources provided for by Federal law, and the risk adjustment program is not specifically exempted under section 255 of the BBEDCA. Therefore, as clarified in the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2016, the risk adjustment program is subject to sequestration. Under section 256(k)(6) of the BBEDCA and the underlying authority for these programs, funds that are sequestered in fiscal year 2016 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2017 without further Congressional action.

2. Provisions and Parameters for the Permanent Risk Adjustment Program

In subparts D and G of 45 CFR part 153, we established standards for the administration of the risk adjustment program. The risk adjustment program is a permanent program created by section 1343 of the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. In accordance with § 153.310(a), a State that is approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf.

On January 8, 2016, we announced that HHS will hold a public conference to discuss potential improvements to the HHS risk adjustment methodology for the 2018 benefit year and beyond. The conference will take place on March 31, 2016, in the Grand Auditorium at the Centers for Medicare and Medicaid Services in Baltimore, Maryland.[10] Prior to the conference, we intend to issue a White Paper that will be open for public comment. The conference and White Paper will focus on what we have learned from the 2014 benefit year of the risk adjustment program, and specific areas of potential refinements to the methodology, including prescription drug model exploration, accounting for partial year enrollment, future recalibrations using risk adjustment data, and discussion of the risk adjustment transfer formula. Registration for the conference opened on January 25, 2016, and is available at *https://www.regtap.info/* until March 23, 2016, for onsite attendance registration, and March 28, 2016, for remote attendance registration. Stakeholders who are unable to attend

[9] Office of Management and Budget, OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2016 (Feb. 2, 2015), available at *https://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration/2016_jc_sequestration_report_speaker.pdf.*

[10] HHS-Operated Risk Adjustment Methodology Meeting; March 31, 2016, 81 FR 4633 (Jan. 27, 2016).

the conference in person may live stream the conference and provide feedback via the webinar. Additional information can be found at *https://www.regtap.info/RAonsite.php.*

a. Overview of the HHS Risk Adjustment Model (§ 153.320)

The HHS risk adjustment model predicts plan liability for an average enrollee based on that person's age, sex, and diagnoses (risk factors), producing a risk score. The HHS risk adjustment methodology utilizes separate models for adults, children, and infants to account for cost differences in each of these age groups. In each of the adult and child models, the relative costs assigned to an individual's age, sex, and diagnoses are added together to produce a risk score. Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups, based on the infant's maturity and the severity of its diagnoses. If applicable, the risk score is multiplied by a cost-sharing reduction adjustment.

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment-covered plan, or the plan liability risk score, within a geographic rating area is one of the inputs into the risk adjustment payment transfer formula, which determines the payment or charge that an issuer will receive or be required to pay for that plan. Thus, the HHS risk adjustment model predicts average group costs to account for risk across plans, which, as we stated in the 2014 Payment Notice, accords with the Actuarial Standards Board's Actuarial Standards of Practice for risk classification.

We received several general comments regarding the HHS risk adjustment methodology.

Comment: Many commenters reiterated their support for the HHS risk adjustment methodology. Some commenters requested a cap on risk adjustment transfers. Some commenters also suggested that, under our methodology, low-cost and low-risk-score issuers subsidize higher cost issuers, and that the model has adverse effects on limited network plans and new, small, and fast-growing plans. Commenters requested exempting new, small, and fast-growing plans from risk adjustment for the first 3 to 5 plan years, in recognition of the difficulty they are having in obtaining complete hierarchical condition categories (HCC) diagnostic classifications for their enrollees. Commenters also suggested gradually phasing in new issuers to risk adjustment or instituting a credibility threshold for participation. One commenter requested that issuers with fewer than 5,000 enrollees or less than 5 percent market share be exempt from risk adjustment. Two commenters requested that HHS set a cap on risk adjustment transfers based on MLR when the amount of the transfer causes the issuer's MLR to hit 90 percent. Specifically, the commenters requested excluding issuers with an MLR of 90 percent or greater, and capping an issuer's risk adjustment payment once it causes the issuer's MLR to rise to 90 percent.

Response: We agree that the risk adjustment program is intended to work with the fair rating rules under the Affordable Care Act to reimburse issuers who take on riskier enrollees, not to prevent issuers, including small and fast-growing issuers, from participating in the individual and small group markets. In this final rule, we are finalizing more accurate model coefficients for 2017 benefit year risk adjustment. We will discuss in the upcoming White Paper potential future improvements to the HHS risk adjustment methodology that we believe will continue to improve the accuracy of the model and benefit all consumers and issuers in these markets by helping ensure fair rating practices across those risk pools because issuers will have the expectation of accurate risk adjustment payments. Any changes we make to the HHS risk adjustment methodology would be implemented through rulemaking as necessary.

Comment: One commenter requested that HHS verify that plans that are subject to risk adjustment data validation (RADV) are correctly implementing the definition of small group, suggesting that eligibility can be verified with an employer's wage and tax statements.

Response: We will consider ways to enhance the RADV audits in operationally feasible ways without infringing on the States' primary regulatory and oversight authority over health insurance issuers.

Comment: One commenter recommended that HHS advance its schedule for publishing the proposed Notice of Benefit and Payment Parameters to early fall, and requested that HHS provide a 60-day comment period to allow for more detailed and substantive comments on major proposed changes to the risk adjustment model.

Response: We are exploring our flexibility in moving the Payment Notice schedule to an earlier timeframe.

b. Proposed Updates to the Risk Adjustment Model (§ 153.320)

In the proposed rule, we proposed to continue to use the same risk adjustment methodology finalized in the 2014 Payment Notice. We proposed to make certain updates to the risk adjustment model to incorporate preventive services into our simulation of plan liability, and to reflect more current data. The proposed data updates are similar to the ones we effectuated for 2016 risk adjustment in the 2016 Payment Notice. We proposed to recalculate the weights assigned to the various hierarchical condition categories and demographic factors in our risk adjustment models using the most recent data available. As we previously described, in the adult and child models, enrollee health risks are estimated using the HHS risk adjustment model, which assigns a set of additive factors that reflect the relative costs attributable to demographics and diagnoses. Risk adjustment factors are developed using claims data and reflect the costs of a given disease relative to average spending. The longer the lag in data used to develop the risk factors, the greater the potential that the costs of treating one disease versus another have changed in a manner not fully reflected in the risk factors.

To provide risk adjustment factors that best reflect more recent treatment patterns and costs, we proposed to recalibrate the HHS risk adjustment models for 2017 by using more recent claims data to develop updated risk factors. The risk factors published in the proposed 2017 Payment Notice were developed using the Truven Health Analytics 2012 and 2013 MarketScan® Commercial Claims and Encounters database (MarketScan); we proposed to update the risk factors in the HHS risk adjustment model using 2012, 2013, and 2014 MarketScan data in the final 2017 Payment Notice when 2014 MarketScan became available. In using 2012, 2013, and 2014 MarketScan data, we blend, or average, the resulting coefficients from the separately solved models from each dataset. We do not weight one year more heavily than the others.

We stated that we believe we can more accurately account for high-cost conditions with new treatments that are not reflected in our model due to lags in the data available to us for recalibration. We believe that stability across our models is important, but sought comment and data that may inform better methods of accurately compensating for new treatments for high cost conditions. For example, we

sought comment on whether there are ways to model the severity of these conditions in a manner that will more fully capture the highest cost enrollees.

Comment: One commenter requested that HHS incorporate 2014 and 2015 data for the individual and small group populations subject to risk adjustment, giving issuers notice of this incorporation no later than December 2016, so that they can determine and file plan year 2018 rates with each State.

Response: Under our current distributed data collection approach, we do not have access to enrollee-level data, which is necessary for risk adjustment recalibration. However, we intend to discuss incorporating enrollee-level data in future recalibrations in the upcoming White Paper, which will be published for public comment.

Comment: Commenters stated that risk adjustment coefficients are too low for enrollees without HCCs and too high for those with one or more HCCs. One commenter recommended that the adult and child models be calculated regionally or specifically for each State. One commenter encouraged HHS to include socioeconomic status and oral health services in the model, especially the child model.

Response: We have attempted to address the range between enrollees without HCCs and those with HCCs by finalizing the incorporation of preventive services into our simulation of plan liability. While overall this is not a very large effect, it does have a noticeable effect on certain demographic subgroups, resulting in more accurate payments for enrollees without HCCs. As for calculating the adult and child models regionally or by State, we believe that the use of the geographic cost factor (GCF) in the payment transfer formula should reflect prevailing utilization and expenditure patterns in the geographic location of the plan's enrollees. We intend to explore whether accounting for socioeconomic status is feasible in the risk adjustment model in the future.

Comment: All commenters on this section of the proposed rule supported HHS's efforts to make the risk adjustment models more accurate by addressing the lag in available health claims data. Many commenters also supported various approaches in more accurately addressing high-cost conditions, which are particularly susceptible to the lag in health claims costs because of the rapidly rising costs of certain specialty drugs. One commenter opposed the use of 2014 data unless the updated model is provided in time to be used for 2017 rate filings. Conversely, another commenter recommended HHS use 2013, 2014, and 2015 MarketScan data for 2017 risk adjustment, and 2014, 2015, and 2016 MarketScan data for 2018 risk adjustment, stating that HHS should finalize the process and methodology in each year's Payment Notice and release the updated factors later. A commenter acknowledged that the incorporation of new 2014 data in the calibration of the risk weights helps address new high-cost treatments, but that under the current model, the benefits of the modification are limited because the use of 3-year averaging means it will take 3 years for the risk weights to fully reflect changes in treatment patterns. Commenters recommended that HHS consider whether individual market data might show different relative weights for certain high-cost conditions than the population currently used for the risk adjustment calibration. Commenters also recommended that HHS evaluate the increase in costs for chronic conditions (specifically Hepatitis C, for which expensive prescription drug therapies have become recently available) year over year and trend or adjust the aggregated claims data or model to reflect the changes—this would allow HHS to respond to changes in treatment practices without relying on additional external data. One commenter recommended that more weight and credibility should be given to the most recent data to best capture emerging trends in treatments, drug therapies, and costs.

Response: We agree with commenters that there may be more precise ways to trend expenditures to accommodate the data lag and more accurately reflect the introduction of new treatments, including prescription drug therapies, for high cost conditions. Based on commenters' feedback on the need to better model the risk of high-cost conditions and rapidly changing health care costs, we re-examined the underlying trend factor we used to trend medical and prescription drug expenditures in the MarketScan data, because those expenditures account for a large portion of the recent changes in costs to treat high-cost conditions. Because we were using the same trend for both sets of expenditures, we looked at historical MarketScan drug data, subdivided by traditional (including branded and generic) drugs, specialty drugs, and medical and surgical expenditures, and found varying growth rates. In order to address commenters' feedback, we consulted with actuaries and industry reports to derive a specialty drug trend rate and traditional drug trend rate through 2017. We believe that using these more granular trend rates better reflect the growth in specialty drug expenditures and drugs generally as compared to medical and surgical expenditures. Further, we believe that more accurately trending drug expenditures through 2017 will more accurately compensate issuers providing new treatments associated with specific HCCs by providing a more finely tuned estimate of the relative costs of various conditions under the HHS risk adjustment methodology. We have incorporated different trend factors for (i) traditional drugs, (ii) specialty drugs, and (iii) medical and surgical expenditures, and are finalizing this approach for 2017 risk adjustment. This approach is reflected in the finalized coefficients in this final rule.

We proposed to incorporate preventive services into our simulation of plan liability in the recalibration of the risk adjustment models for 2017. We identified preventive services for the 2012, 2013, and 2014 MarketScan samples using procedure and diagnosis codes, prescription drug therapeutic classes, and enrollee age and sex. We relied on lists of preventive services from several major issuers, the preventive services used for the AV Calculator, and Medicare's preventive services benefit to operationalize preventive services definitions for incorporation in the risk adjustment models. We then adjusted plan liability by adding 100 percent of preventive services covered charges to simulate plan liability for all metal levels. We also applied standard benefit cost sharing rules by metal level to covered charges for non-preventive services. Total adjusted simulated plan liability is the sum of preventive services covered charges, and non-preventive services simulated plan liability.

We re-estimated the risk adjustment models by metal level, predicting plan liability adjusted to account for preventive services without cost sharing. We compared the model coefficients predicting original (that is, non-adjusted for preventive services) and adjusted simulated plan liability. Adjusting for preventive services increases age-sex coefficients relative to HCC coefficients, especially in the lower metal tiers (bronze and silver), and in age/sex ranges with high preventive services expenditures (for example, young adult females). The implication of the changes to the model coefficients is that the risk scores of healthy enrollees (whose risk scores are based solely on model age-sex coefficients) will likely rise relative to the risk scores of the less healthy (whose risk scores

include one or more HCC coefficients in addition to an age-sex coefficient), especially in bronze and silver plans. As a result of the risk score changes for individuals, we expect that the incorporation of preventive services will increase the risk scores of bronze and silver plans with healthier enrollees relative to other plans' risk scores when preventive services are taken into account. This incorporation of preventive services will more accurately compensate risk adjustment covered plans with enrollees who use preventive services.

Comment: Most commenters supported the incorporation of preventive services into our simulation of plan liability in the risk adjustment model. Two commenters expressed concern that this change would unintentionally create an incentive for issuers to attract and retain healthier individuals rather than higher risk individuals, while another commenter supported including preventive services, but suggested that the approach proposed by HHS appears to compensate all plans, regardless of whether their members receive preventive services, thereby creating a ''free rider'' problem. One commenter noted that while the incorporation of preventive services does increase demographic factors for catastrophic plans and for females within bronze plans, the impact of this change is relatively small and does not resolve concerns about unbalanced incentives to attract enrollees with HCC diagnoses.

Response: Section 2713 of the PHS Act, as added by the Affordable Care Act requires that individual and small group non-grandfathered plans (among others) provide coverage for a range of preventive services and may not impose cost sharing on patients receiving these services. We believe it is essential that we are consistent with the goals of the Affordable Care Act and provide compensation to issuers who are required to provide these services without cost sharing. As such, we also believe that accurately accounting for services provided by issuers to healthier enrollees is a fair adjustment to real, baseline costs paid by these issuers. As for concerns about a ''free rider'' problem, all risk adjustment covered plans are required to provide zero cost sharing preventive services. Even if different enrollees use preventive services to different extents, by incorporating zero cost sharing preventive services in the calculation of plan liability when calibrating the models' coefficients, we will increase the accuracy of the model overall, accounting for any differential use of preventive services at the plan level. We believe that this increased accuracy for demographic factors coupled with our adjustments to medical and prescription drug expenditures will promote increased accuracy for all enrollees, with and without HCCs. We are finalizing the incorporation of preventive services into our simulation of plan liability as proposed.

Additionally, we are evaluating whether and how we may incorporate prescription drug data in the Federally certified risk adjustment methodology that HHS uses when it operates risk adjustment. Prescription drug data could be used in the risk adjustment methodology to supplement diagnostic data by using the prescription drug data as a severity indicator, or as a proxy for diagnoses in cases where diagnostic data are likely to be incomplete. We are assessing these approaches, with particular sensitivity to reliability and the potential for strategic behavior with respect to prescribing behavior. As we noted in the 2014 Payment Notice, we did not use prescription drug utilization as a predictor of expenditures to avoid creating adverse incentives to modify discretionary prescribing. We are evaluating whether we can improve the models' predictive power through the incorporation of prescription drugs without unduly incentivizing altered prescribing behavior. We sought comment and any data that could inform effective methods of incorporating prescription drug data in future recalibrations.

Comment: Most commenters supported incorporating prescription drugs as predictors in the risk adjustment model either as a proxy for missing diagnoses or an indicator of severity. Some commenters shared HHS's concerns about creating incentives to modify discretionary prescribing to artificially increase the severity of diagnoses and one commenter expressed concern about keeping the model current with pharmaceutical developments that could create an additional operational burden for both health plans and HHS. Some commenters suggested that prescription drugs be included for 2017 risk adjustment. One commenter requested that HHS incorporate prescription drugs as soon as possible. Commenters supported 2018 implementation (rather than 2017) and one commenter suggested that any changes to include prescription drugs should include greater detail and go through the regular notice and comment process. Commenters suggested that HHS include prescription drug data in a limited manner, such as drugs with no off label use or drugs approved for treatment of a single condition. One commenter recommended that all prescription drugs used to treat HCC conditions be included. Commenters stated that including prescription drugs could significantly increase payment accuracy and yield benefits to the payment system far in excess of any additional administrative burden. Commenters further stated that prescription drug claims data have certain advantages in that the data are fairly uniform across plans and do not have many of the issues associated with diagnosis data, such as timeliness and inconsistency of reporting across providers, in addition to already being included in EDGE Server data and readily available to HHS. Commenters also stated that including prescription drugs as a proxy for missing diagnoses could level the playing field for smaller issuers that are less experienced with medical coding. Similarly, commenters supported the inclusion of pharmacy data to address partial year enrollees with chronic conditions that have prescription drug claims, but may not have a provider encounter with a documented diagnosis. One commenter requested that HHS work with stakeholders to refine the prescription drug data that would be utilized if this proposal is finalized and requested that HHS consider how to gather and incorporate data on prescription drug utilization collected by electronic health records. Commenters cautioned HHS to be mindful that different characteristics of prescription drug utilization will be more or less predictive depending on the condition. Commenters also warned that gaming concerns need to be balanced with the desire to enhance the risk adjustment methodology's predictive power. A commenter also cautioned that the proposed use of prescription drug data should have definitions and guardrails that delineate its use. Lastly, commenters stated that using prescription drug data is important because without an accurate risk adjustment methodology that accounts for the extra costs that plans incur by enrolling high-risk patients, plans have an incentive to design benefits in a manner that discourages enrollment by these patients.

Response: We will explore the incorporation of prescription drugs in the risk adjustment model in the White Paper and at the conference in March 2016. We agree with commenters that prescription drugs have the potential to increase the predictive power of the risk adjustment models. We agree that different prescription drugs will likely

be more or less predictive depending on the condition. We also remain cautious about creating incentives to modify discretionary prescribing to artificially increase the severity of diagnoses. However, we look forward to continuing to explore this potential improvement to the models with stakeholders and to share our developments in the White Paper and at the risk adjustment conference on March 31, 2016.

Lastly, we stated in the proposed rule that we would like to explore the effect of partial year enrollment in the HHS risk adjustment methodology. We have received input that issuers are experiencing higher than expected claims costs for partial year enrollees. We have also received input that the methodology does not capture enrollees with chronic conditions who may not have accumulated diagnoses in their partial year enrollment. At the same time, as compared to full year enrollees of the same relative risk, partial year enrollees are less likely to have spending that exceeds the deductible or annual limitation on cost sharing. We sought comment on how the methodology could be made more predictive for partial year enrollees.

Comment: Many commenters supported addressing partial year enrollees in the model. One commenter noted that many medical events for enrollees in the commercial market (for example, maternity, surgeries) represent acute rather than chronic events, so the enrollee can incur most of their annual medical expenses during a short period of time. Commenters suggested that the use of prescription drug claims could help address enrollees with a chronic condition but who do not have a provider encounter with a documented diagnosis. Commenters also suggested that the impact of partial year enrollment could be measured by taking a population that had multiple years of enrollment and comparing risk scores and health care costs when only a partial year is considered. Commenters noted Massachusetts' adjustment for partial-year enrollment, and suggested that HHS consider additional analysis to determine whether that approach is appropriate for the HHS risk adjustment methodology. One commenter suggested a member-level adjustment while another commenter suggested a duration-based adjustment. Another commenter recommended that the adjustment vary by metal level and length of time enrolled, with higher weights for gold and platinum plans and shorter enrollment periods. One commenter suggested that HHS should permit risk scores to travel with an enrollee across issuers. Two commenters opposed an explicit adjustment for partial year enrollees, because they said such an adjustment would accommodate liberal enforcement of special enrollment periods, incentivizing issuers to employ loose eligibility standards to gain members, but ultimately eroding individual market stability. A few commenters recommended that to better address partial year enrollment in risk adjustment, changes should be made to special enrollment period processes and policies to encourage continuous coverage and prevent fraud and abuse. Commenters stated that unverified special enrollment periods have produced selection issues for health plans, as enrollees enter through a special enrollment period, utilize high-cost services, and then switch to a lower metal level plan in the following open enrollment period or drop coverage altogether. One commenter cautioned that any additions to the model to account for partial year enrollment should improve reliability and predictive power, not influence clinical judgment or plan behavior with respect to enrollees' coverage.

Response: We appreciate commenters' substantive feedback on accounting for partial year enrollment in future recalibrations and will continue to analyze this issue and include our findings in the White Paper for discussion at the March 31, 2016 risk adjustment conference.

c. List of Factors To Be Employed in the Model (§ 153.320)

The HHS risk adjustment models predict annualized plan liability expenditures using age and sex categories and the HHS HCCs included in the HHS risk adjustment model. Dollar coefficients were estimated for these factors using weighted least squares regression, where the weight was the fraction of the year enrolled.

We are including the same HCCs that were included in the original risk adjustment calibration in the 2014 Payment Notice. For each model, the factors are the statistical regression dollar values for each HCC in the model divided by a weighted average plan liability for the full modeling sample. The factors represent the predicted relative incremental expenditures for each HCC. The factors resulting from the blended factors from the 2012, 2013, and 2014 separately solved models (with the incorporation of preventive services, and with different trend rates for medical and surgical expenditures, for traditional prescription drug expenditures, and for specialty prescription drug expenditures) are shown in the tables below. For a given enrollee, the sums of the factors for the enrollee's HCCs are the total relative predicted expenditures for that enrollee. Table 1 contains factors for each adult model, including the interactions. Table 2 contains the HHS HCCs in the severity illness indicator variable. Table 3 contains the factors for each child model. Table 4 contains the factors for each infant model. We are finalizing these factors, with the adjustment for the differing medical and traditional and specialty prescription drug trend factors incorporated in the 2012, 2013, and 2014 blended coefficients.

TABLE 1—ADULT RISK ADJUSTMENT MODEL FACTORS

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors					
Age 21–24, Male	0.236	0.180	0.119	0.082	0.081
Age 25–29, Male	0.246	0.186	0.122	0.083	0.082
Age 30–34, Male	0.287	0.216	0.138	0.089	0.088
Age 35–39, Male	0.346	0.264	0.172	0.112	0.111
Age 40–44, Male	0.420	0.326	0.221	0.151	0.149
Age 45–49, Male	0.496	0.392	0.273	0.192	0.191
Age 50–54, Male	0.633	0.512	0.372	0.275	0.274
Age 55–59, Male	0.722	0.585	0.429	0.320	0.318
Age 60–64, Male	0.843	0.683	0.502	0.372	0.369
Age 21–24, Female	0.379	0.296	0.200	0.138	0.137
Age 25–29, Female	0.460	0.359	0.247	0.173	0.172

TABLE 1—ADULT RISK ADJUSTMENT MODEL FACTORS—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Age 30–34, Female	0.582	0.466	0.337	0.254	0.252
Age 35–39, Female	0.668	0.542	0.405	0.318	0.316
Age 40–44, Female	0.742	0.604	0.455	0.357	0.355
Age 45–49, Female	0.750	0.608	0.450	0.344	0.342
Age 50–54, Female	0.845	0.691	0.518	0.398	0.395
Age 55–59, Female	0.849	0.690	0.510	0.380	0.378
Age 60–64, Female	0.909	0.734	0.537	0.395	0.392
Diagnosis Factors					
HIV/AIDS	8.942	8.450	8.099	8.142	8.143
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	10.686	10.511	10.405	10.461	10.462
Central Nervous System Infections, Except Viral Meningitis	6.632	6.532	6.468	6.489	6.489
Viral or Unspecified Meningitis	4.657	4.422	4.263	4.222	4.222
Opportunistic Infections	8.503	8.404	8.337	8.319	8.319
Metastatic Cancer	24.314	23.880	23.578	23.637	23.638
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.630	12.296	12.062	12.066	12.066
Non-Hodgkin's Lymphomas and Other Cancers and Tumors	5.845	5.611	5.435	5.388	5.387
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	5.152	4.918	4.738	4.690	4.689
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	2.957	2.786	2.650	2.597	2.596
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.448	1.295	1.160	1.069	1.067
Pancreas Transplant Status/Complications	5.455	5.233	5.091	5.112	5.114
Diabetes with Acute Complications	1.187	1.049	0.925	0.822	0.820
Diabetes with Chronic Complications	1.187	1.049	0.925	0.822	0.820
Diabetes without Complication	1.187	1.049	0.925	0.822	0.820
Protein-Calorie Malnutrition	13.686	13.693	13.702	13.762	13.763
Mucopolysaccharidosis	2.277	2.159	2.061	2.008	2.007
Lipidoses and Glycogenosis	2.277	2.159	2.061	2.008	2.007
Amyloidosis, Porphyria, and Other Metabolic Disorders	2.277	2.159	2.061	2.008	2.007
Adrenal, Pituitary, and Other Significant Endocrine Disorders	2.277	2.159	2.061	2.008	2.007
Liver Transplant Status/Complications	16.042	15.868	15.759	15.771	15.772
End-Stage Liver Disease	7.119	6.877	6.718	6.736	6.737
Cirrhosis of Liver	3.852	3.690	3.569	3.535	3.535
Chronic Hepatitis	3.852	3.690	3.569	3.535	3.535
Acute Liver Failure/Disease, Including Neonatal Hepatitis	4.430	4.269	4.158	4.148	4.148
Intestine Transplant Status/Complications	32.604	32.555	32.516	32.559	32.559
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	11.820	11.561	11.383	11.413	11.413
Intestinal Obstruction	6.537	6.272	6.101	6.120	6.121
Chronic Pancreatitis	5.455	5.233	5.091	5.112	5.114
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.702	2.515	2.379	2.331	2.331
Inflammatory Bowel Disease	3.657	3.392	3.190	3.098	3.096
Necrotizing Fasciitis	6.576	6.378	6.239	6.254	6.255
Bone/Joint/Muscle Infections/Necrosis	6.576	6.378	6.239	6.254	6.255
Rheumatoid Arthritis and Specified Autoimmune Disorders	4.848	4.587	4.394	4.385	4.385
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.205	1.070	0.952	0.868	0.867
Osteogenesis Imperfecta and Other Osteodystrophies	3.115	2.917	2.758	2.699	2.697
Congenital/Developmental Skeletal and Connective Tissue Disorders	3.115	2.917	2.758	2.699	2.697
Cleft Lip/Cleft Palate	1.295	1.137	1.010	0.942	0.941
Hemophilia	46.436	46.150	45.931	45.939	45.939
Myelodysplastic Syndromes and Myelofibrosis	12.671	12.534	12.440	12.448	12.449
Aplastic Anemia	12.671	12.534	12.440	12.448	12.449
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	9.737	9.576	9.454	9.445	9.445
Sickle Cell Anemia (Hb-SS)	9.737	9.576	9.454	9.445	9.445
Thalassemia Major	9.737	9.576	9.454	9.445	9.445
Combined and Other Severe Immunodeficiencies	5.432	5.284	5.182	5.183	5.183
Disorders of the Immune Mechanism	5.432	5.284	5.182	5.183	5.183
Coagulation Defects and Other Specified Hematological Disorders	2.805	2.707	2.628	2.599	2.599
Drug Psychosis	3.830	3.574	3.380	3.286	3.284
Drug Dependence	3.830	3.574	3.380	3.286	3.284

TABLE 1—ADULT RISK ADJUSTMENT MODEL FACTORS—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Schizophrenia	3.189	2.934	2.744	2.680	2.679
Major Depressive and Bipolar Disorders	1.714	1.547	1.404	1.308	1.307
Reactive and Unspecified Psychosis, Delusional Disorders	1.714	1.547	1.404	1.308	1.307
Personality Disorders	1.176	1.043	0.910	0.814	0.812
Anorexia/Bulimia Nervosa	2.693	2.527	2.392	2.334	2.333
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	2.632	2.504	2.403	2.354	2.353
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.056	0.951	0.849	0.778	0.776
Autistic Disorder	1.176	1.043	0.910	0.814	0.812
Pervasive Developmental Disorders, Except Autistic Disorder	1.176	1.043	0.910	0.814	0.812
Traumatic Complete Lesion Cervical Spinal Cord	12.005	11.851	11.737	11.735	11.735
Quadriplegia	12.005	11.851	11.737	11.735	11.735
Traumatic Complete Lesion Dorsal Spinal Cord	9.157	9.000	8.886	8.874	8.875
Paraplegia	9.157	9.000	8.886	8.874	8.875
Spinal Cord Disorders/Injuries	5.635	5.424	5.275	5.246	5.246
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	3.029	2.792	2.625	2.585	2.585
Quadriplegic Cerebral Palsy	1.206	0.997	0.839	0.777	0.776
Cerebral Palsy, Except Quadriplegic	0.124	0.068	0.034	0.011	0.011
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	0.071	0.019	0.000	0.000	0.000
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.247	5.099	4.994	4.971	4.971
Muscular Dystrophy	2.147	1.981	1.860	1.785	1.784
Multiple Sclerosis	13.590	13.187	12.905	12.950	12.951
Parkinson‘s, Huntington‘s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.147	1.981	1.860	1.785	1.784
Seizure Disorders and Convulsions	1.495	1.337	1.207	1.137	1.136
Hydrocephalus	6.388	6.266	6.165	6.139	6.138
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	9.207	9.070	8.964	8.958	8.957
Respirator Dependence/Tracheostomy Status	34.719	34.708	34.706	34.772	34.773
Respiratory Arrest	10.554	10.403	10.306	10.370	10.371
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	10.554	10.403	10.306	10.370	10.371
Heart Assistive Device/Artificial Heart	35.114	34.869	34.711	34.771	34.772
Heart Transplant	35.114	34.869	34.711	34.771	34.772
Congestive Heart Failure	3.280	3.171	3.095	3.089	3.089
Acute Myocardial Infarction	10.129	9.795	9.580	9.691	9.693
Unstable Angina and Other Acute Ischemic Heart Disease	5.227	4.952	4.779	4.793	4.794
Heart Infection/Inflammation, Except Rheumatic	6.297	6.163	6.063	6.042	6.041
Specified Heart Arrhythmias	2.829	2.681	2.565	2.512	2.511
Intracranial Hemorrhage	9.423	9.144	8.954	8.963	8.964
Ischemic or Unspecified Stroke	3.167	2.982	2.869	2.875	2.876
Cerebral Aneurysm and Arteriovenous Malformation	3.940	3.742	3.600	3.559	3.558
Hemiplegia/Hemiparesis	5.468	5.374	5.317	5.360	5.361
Monoplegia, Other Paralytic Syndromes	3.452	3.319	3.226	3.207	3.207
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.940	10.840	10.784	10.853	10.854
Vascular Disease with Complications	7.727	7.543	7.416	7.417	7.417
Pulmonary Embolism and Deep Vein Thrombosis	3.841	3.675	3.555	3.529	3.529
Lung Transplant Status/Complications	36.419	36.227	36.103	36.180	36.181
Cystic Fibrosis	18.011	17.687	17.444	17.467	17.467
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.942	0.825	0.717	0.641	0.640
Asthma	0.942	0.825	0.717	0.641	0.640
Fibrosis of Lung and Other Lung Disorders	1.889	1.771	1.682	1.641	1.640
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	7.594	7.520	7.471	7.485	7.485
Kidney Transplant Status	10.183	9.919	9.744	9.735	9.735
End Stage Renal Disease	38.463	38.228	38.078	38.198	38.201
Chronic Kidney Disease, Stage 5	2.088	1.989	1.925	1.920	1.920
Chronic Kidney Disease, Severe (Stage 4)	2.088	1.989	1.925	1.920	1.920
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.340	1.156	0.979	0.795	0.791
Miscarriage with Complications	1.340	1.156	0.979	0.795	0.791
Miscarriage with No or Minor Complications	1.340	1.156	0.979	0.795	0.791
Completed Pregnancy With Major Complications	3.630	3.150	2.862	2.712	2.713
Completed Pregnancy With Complications	3.630	3.150	2.862	2.712	2.713
Completed Pregnancy with No or Minor Complications	3.630	3.150	2.862	2.712	2.713

TABLE 1—ADULT RISK ADJUSTMENT MODEL FACTORS—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Chronic Ulcer of Skin, Except Pressure	2.356	2.233	2.150	2.134	2.134
Hip Fractures and Pathological Vertebral or Humerus Fractures	9.460	9.245	9.100	9.136	9.136
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	2.000	1.871	1.758	1.688	1.687
Stem Cell, Including Bone Marrow, Transplant Status/Complications	31.027	31.022	31.017	31.035	31.036
Artificial Openings for Feeding or Elimination	10.038	9.946	9.886	9.924	9.925
Amputation Status, Lower Limb/Amputation Complications	5.263	5.112	5.015	5.044	5.045
Interaction Factors					
Severe illness x Opportunistic Infections	10.408	10.632	10.799	10.894	10.895
Severe illness x Metastatic Cancer	10.408	10.632	10.799	10.894	10.895
Severe illness x Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	10.408	10.632	10.799	10.894	10.895
Severe illness x Non-Hodgkin's Lymphomas and Other Cancers and Tumors	10.408	10.632	10.799	10.894	10.895
Severe illness x Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	10.408	10.632	10.799	10.894	10.895
Severe illness x Heart Infection/Inflammation, Except Rheumatic	10.408	10.632	10.799	10.894	10.895
Severe illness x Intracranial Hemorrhage	10.408	10.632	10.799	10.894	10.895
Severe illness x HCC group G06 (G06 is HCC Group 6 which includes the following HCCs in the blood disease category: 67, 68)	10.408	10.632	10.799	10.894	10.895
Severe illness x HCC group G08 (G08 is HCC Group 8 which includes the following HCCs in the blood disease category: 73, 74)	10.408	10.632	10.799	10.894	10.895
Severe illness x End-Stage Liver Disease	1.906	2.039	2.141	2.225	2.226
Severe illness x Acute Liver Failure/Disease, Including Neonatal Hepatitis	1.906	2.039	2.141	2.225	2.226
Severe illness x Atherosclerosis of the Extremities with Ulceration or Gangrene	1.906	2.039	2.141	2.225	2.226
Severe illness x Vascular Disease with Complications	1.906	2.039	2.141	2.225	2.226
Severe illness x Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	1.906	2.039	2.141	2.225	2.226
Severe illness x Artificial Openings for Feeding or Elimination	1.906	2.039	2.141	2.225	2.226
Severe illness x HCC group G03 (G03 is HCC Group 3 which includes the following HCCs in the musculoskeletal disease category: 54, 55)	1.906	2.039	2.141	2.225	2.226

TABLE 2—HHS HCCS IN THE SEVERITY ILLNESS INDICATOR VARIABLE

Description
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock.
Peritonitis/Gastrointestinal Perforation/Necrotizing Enter colitis.
Seizure Disorders and Convulsions.
Non-Traumatic Coma, Brain Compression/Anoxic Damage.
Respirator Dependence/Tracheostomy Status.
Respiratory Arrest.
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes.
Pulmonary Embolism and Deep Vein Thrombosis.

TABLE 3—CHILD RISK ADJUSTMENT MODEL FACTORS

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors					
Age 2–4, Male	0.224	0.145	0.067	0.021	0.020
Age 5–9, Male	0.155	0.098	0.038	0.004	0.004
Age 10–14, Male	0.220	0.158	0.089	0.053	0.053
Age 15–20, Male	0.290	0.219	0.142	0.097	0.096
Age 2–4, Female	0.178	0.109	0.044	0.011	0.010
Age 5–9, Female	0.127	0.076	0.027	0.003	0.002
Age 10–14, Female	0.204	0.145	0.085	0.054	0.054

TABLE 3—CHILD RISK ADJUSTMENT MODEL FACTORS—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Age 15–20, Female	0.330	0.248	0.157	0.101	0.100
Diagnosis Factors					
HIV/AIDS	4.875	4.437	4.110	4.033	4.032
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	17.228	17.069	16.969	16.994	16.995
Central Nervous System Infections, Except Viral Meningitis	10.808	10.631	10.506	10.511	10.511
Viral or Unspecified Meningitis	3.128	2.925	2.775	2.687	2.686
Opportunistic Infections	22.943	22.880	22.834	22.825	22.825
Metastatic Cancer	36.648	36.404	36.207	36.207	36.207
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.117	11.833	11.604	11.547	11.546
Non-Hodgkin's Lymphomas and Other Cancers and Tumors	9.328	9.058	8.836	8.754	8.753
Colorectal, Breast (Age <50), Kidney, and Other Cancers	3.508	3.291	3.097	2.989	2.987
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	3.016	2.816	2.642	2.538	2.537
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.723	1.553	1.397	1.294	1.292
Pancreas Transplant Status/Complications	30.468	30.333	30.245	30.256	30.256
Diabetes with Acute Complications	2.521	2.197	1.946	1.703	1.699
Diabetes with Chronic Complications	2.521	2.197	1.946	1.703	1.699
Diabetes without Complication	2.521	2.197	1.946	1.703	1.699
Protein-Calorie Malnutrition	13.570	13.484	13.421	13.450	13.450
Mucopolysaccharidosis	8.509	8.238	8.020	7.987	7.986
Lipidoses and Glycogenosis	8.509	8.238	8.020	7.987	7.986
Congenital Metabolic Disorders, Not Elsewhere Classified	8.509	8.238	8.020	7.987	7.986
Amyloidosis, Porphyria, and Other Metabolic Disorders	8.509	8.238	8.020	7.987	7.986
Adrenal, Pituitary, and Other Significant Endocrine Disorders	8.509	8.238	8.020	7.987	7.986
Liver Transplant Status/Complications	30.468	30.333	30.245	30.256	30.256
End-Stage Liver Disease	13.077	12.927	12.822	12.821	12.821
Cirrhosis of Liver	9.604	9.445	9.326	9.286	9.286
Chronic Hepatitis	2.567	2.418	2.280	2.216	2.215
Acute Liver Failure/Disease, Including Neonatal Hepatitis	12.729	12.576	12.460	12.447	12.447
Intestine Transplant Status/Complications	30.468	30.333	30.245	30.256	30.256
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	14.795	14.463	14.217	14.238	14.238
Intestinal Obstruction	5.389	5.155	4.965	4.885	4.884
Chronic Pancreatitis	9.713	9.478	9.319	9.319	9.319
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	2.561	2.426	2.303	2.217	2.216
Inflammatory Bowel Disease	6.321	5.943	5.650	5.553	5.551
Necrotizing Fasciitis	4.467	4.231	4.041	3.989	3.988
Bone/Joint/Muscle Infections/Necrosis	4.467	4.231	4.041	3.989	3.988
Rheumatoid Arthritis and Specified Autoimmune Disorders	3.904	3.662	3.448	3.365	3.364
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.305	1.154	1.003	0.893	0.891
Osteogenesis Imperfecta and Other Osteodystrophies	1.560	1.429	1.303	1.232	1.231
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.560	1.429	1.303	1.232	1.231
Cleft Lip/Cleft Palate	1.563	1.351	1.172	1.061	1.059
Hemophilia	66.792	66.309	65.939	65.927	65.927
Myelodysplastic Syndromes and Myelofibrosis	15.978	15.807	15.672	15.654	15.654
Aplastic Anemia	15.978	15.807	15.672	15.654	15.654
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	7.706	7.432	7.214	7.145	7.144
Sickle Cell Anemia (Hb-SS)	7.706	7.432	7.214	7.145	7.144
Thalassemia Major	7.706	7.432	7.214	7.145	7.144
Combined and Other Severe Immunodeficiencies	6.686	6.507	6.364	6.310	6.309
Disorders of the Immune Mechanism	6.686	6.507	6.364	6.310	6.309
Coagulation Defects and Other Specified Hematological Disorders	4.828	4.689	4.560	4.494	4.493
Drug Psychosis	5.390	5.135	4.948	4.887	4.887
Drug Dependence	5.390	5.135	4.948	4.887	4.887
Schizophrenia	5.242	4.853	4.561	4.472	4.471
Major Depressive and Bipolar Disorders	1.913	1.691	1.485	1.334	1.332
Reactive and Unspecified Psychosis, Delusional Disorders	1.913	1.691	1.485	1.334	1.332
Personality Disorders	0.783	0.653	0.504	0.376	0.374
Anorexia/Bulimia Nervosa	2.742	2.539	2.370	2.309	2.308

TABLE 3—CHILD RISK ADJUSTMENT MODEL FACTORS—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	3.362	3.155	3.013	2.980	2.979
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.787	1.605	1.459	1.378	1.376
Autistic Disorder	1.771	1.577	1.389	1.248	1.246
Pervasive Developmental Disorders, Except Autistic Disorder	0.907	0.766	0.597	0.448	0.445
Traumatic Complete Lesion Cervical Spinal Cord	13.209	13.168	13.154	13.225	13.227
Quadriplegia	13.209	13.168	13.154	13.225	13.227
Traumatic Complete Lesion Dorsal Spinal Cord	11.619	11.410	11.267	11.269	11.270
Paraplegia	11.619	11.410	11.267	11.269	11.270
Spinal Cord Disorders/Injuries	4.847	4.614	4.433	4.359	4.358
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	8.218	7.979	7.791	7.744	7.744
Quadriplegic Cerebral Palsy	3.387	3.141	2.983	2.995	2.996
Cerebral Palsy, Except Quadriplegic	0.861	0.675	0.530	0.451	0.450
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	1.282	1.135	1.010	0.944	0.943
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	9.635	9.457	9.315	9.279	9.279
Muscular Dystrophy	3.374	3.176	3.021	2.948	2.947
Multiple Sclerosis	8.431	8.101	7.852	7.820	7.820
Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	3.374	3.176	3.021	2.948	2.947
Seizure Disorders and Convulsions	2.095	1.913	1.735	1.609	1.607
Hydrocephalus	5.122	5.002	4.912	4.903	4.903
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	7.539	7.391	7.276	7.236	7.235
Respirator Dependence/Tracheostomy Status	40.112	40.012	39.969	40.084	40.086
Respiratory Arrest	12.354	12.151	12.015	12.013	12.013
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	12.354	12.151	12.015	12.013	12.013
Heart Assistive Device/Artificial Heart	30.468	30.333	30.245	30.256	30.256
Heart Transplant	30.468	30.333	30.245	30.256	30.256
Congestive Heart Failure	6.999	6.888	6.791	6.751	6.751
Acute Myocardial Infarction	9.715	9.553	9.443	9.441	9.442
Unstable Angina and Other Acute Ischemic Heart Disease	6.438	6.331	6.260	6.262	6.262
Heart Infection/Inflammation, Except Rheumatic	16.113	15.984	15.888	15.866	15.866
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	6.323	6.111	5.905	5.794	5.792
Major Congenital Heart/Circulatory Disorders	1.778	1.651	1.493	1.391	1.389
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	1.202	1.090	0.952	0.872	0.871
Specified Heart Arrhythmias	4.399	4.213	4.049	3.984	3.983
Intracranial Hemorrhage	15.936	15.685	15.510	15.504	15.504
Ischemic or Unspecified Stroke	8.574	8.456	8.381	8.396	8.396
Cerebral Aneurysm and Arteriovenous Malformation	3.865	3.650	3.490	3.433	3.432
Hemiplegia/Hemiparesis	4.815	4.703	4.625	4.610	4.610
Monoplegia, Other Paralytic Syndromes	3.627	3.487	3.391	3.361	3.361
Atherosclerosis of the Extremities with Ulceration or Gangrene	15.571	15.296	15.096	15.012	15.011
Vascular Disease with Complications	18.826	18.672	18.564	18.569	18.569
Pulmonary Embolism and Deep Vein Thrombosis	15.291	15.130	15.023	15.041	15.042
Lung Transplant Status/Complications	30.468	30.333	30.245	30.256	30.256
Cystic Fibrosis	20.415	19.976	19.647	19.686	19.687
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.435	0.348	0.231	0.149	0.147
Asthma	0.435	0.348	0.231	0.149	0.147
Fibrosis of Lung and Other Lung Disorders	4.116	3.973	3.845	3.789	3.788
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	10.256	10.199	10.157	10.177	10.177
Kidney Transplant Status	16.425	16.083	15.843	15.848	15.848
End Stage Renal Disease	39.805	39.631	39.521	39.592	39.593
Chronic Kidney Disease, Stage 5	7.087	6.923	6.771	6.675	6.673
Chronic Kidney Disease, Severe (Stage 4)	7.087	6.923	6.771	6.675	6.673
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.126	0.939	0.750	0.559	0.555
Miscarriage with Complications	1.126	0.939	0.750	0.559	0.555
Miscarriage with No or Minor Complications	1.126	0.939	0.750	0.559	0.555
Completed Pregnancy With Major Complications	3.159	2.712	2.427	2.240	2.240
Completed Pregnancy With Complications	3.159	2.712	2.427	2.240	2.240

TABLE 3—CHILD RISK ADJUSTMENT MODEL FACTORS—Continued

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Completed Pregnancy with No or Minor Complications	3.159	2.712	2.427	2.240	2.240
Chronic Ulcer of Skin, Except Pressure	1.941	1.836	1.731	1.675	1.675
Hip Fractures and Pathological Vertebral or Humerus Fractures	5.725	5.450	5.215	5.124	5.123
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	1.574	1.428	1.264	1.147	1.145
Stem Cell, Including Bone Marrow, Transplant Status/Complications	30.468	30.333	30.245	30.256	30.256
Artificial Openings for Feeding or Elimination	14.575	14.480	14.443	14.551	14.553
Amputation Status, Lower Limb/Amputation Complications	8.195	7.923	7.727	7.631	7.630

TABLE 4—INFANT RISK ADJUSTMENT MODELS FACTORS

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	378.927	377.561	376.491	376.507	376.508
Extremely Immature * Severity Level 4	194.401	193.057	192.003	191.981	191.981
Extremely Immature * Severity Level 3	46.419	45.304	44.390	44.236	44.234
Extremely Immature * Severity Level 2	46.419	45.304	44.390	44.236	44.234
Extremely Immature * Severity Level 1 (Lowest)	46.419	45.304	44.390	44.236	44.234
Immature *Severity Level 5 (Highest)	190.323	189.030	188.013	188.027	188.028
Immature *Severity Level 4	85.852	84.500	83.442	83.437	83.437
Immature *Severity Level 3	46.419	45.304	44.390	44.236	44.234
Immature *Severity Level 2	28.986	27.832	26.907	26.738	26.736
Immature *Severity Level 1 (Lowest)	28.986	27.832	26.907	26.738	26.736
Premature/Multiples * Severity Level 5 (Highest)	156.158	154.846	153.824	153.791	153.791
Premature/Multiples * Severity Level 4	32.573	31.292	30.290	30.173	30.173
Premature/Multiples * Severity Level 3	17.215	16.169	15.315	15.020	15.016
Premature/Multiples * Severity Level 2	8.942	8.081	7.334	6.884	6.876
Premature/Multiples * Severity Level 1 (Lowest)	6.222	5.557	4.867	4.376	4.367
Term *Severity Level 5 (Highest)	130.728	129.499	128.518	128.414	128.413
Term *Severity Level 4	16.874	15.867	15.038	14.685	14.681
Term *Severity Level 3	6.324	5.648	4.969	4.448	4.438
Term *Severity Level 2	3.857	3.319	2.700	2.139	2.128
Term *Severity Level 1 (Lowest)	1.639	1.321	0.772	0.358	0.350
Age1 *Severity Level 5 (Highest)	54.166	53.499	52.963	52.894	52.892
Age1 *Severity Level 4	9.298	8.787	8.351	8.169	8.167
Age1 *Severity Level 3	3.380	3.034	2.676	2.465	2.461
Age1 *Severity Level 2	2.155	1.873	1.549	1.320	1.316
Age1 *Severity Level 1 (Lowest)	0.572	0.441	0.274	0.199	0.197
Age 0 Male	0.685	0.637	0.608	0.554	0.553
Age 1 Male	0.145	0.127	0.106	0.081	0.081

TABLE 5—HHS HCCS INCLUDED IN INFANT MODEL MATURITY CATEGORIES

Maturity category	HCC/description
Extremely Immature	Extremely Immature Newborns, Birthweight < 500 Grams.
Extremely Immature	Extremely Immature Newborns, Including Birthweight 500–749 Grams.
Extremely Immature	Extremely Immature Newborns, Including Birthweight 750–999 Grams.
Immature	Premature Newborns, Including Birthweight 1000–1499 Grams.
Immature	Premature Newborns, Including Birthweight 1500–1999 Grams.
Premature/Multiples	Premature Newborns, Including Birthweight 2000–2499 Grams.
Premature/Multiples	Other Premature, Low Birthweight, Malnourished, or Multiple Birth Newborns.
Term	Term or Post-Term Singleton Newborn, Normal or High Birthweight.
Age 1	All age 1 infants.

TABLE 6—HHS HCCS INCLUDED IN INFANT MODEL SEVERITY CATEGORIES

Severity Category	HCC
Severity Level 5 (Highest)	Metastatic Cancer.
Severity Level 5	Pancreas Transplant Status/Complications.
Severity Level 5	Liver Transplant Status/Complications.
Severity Level 5	End-Stage Liver Disease.
Severity Level 5	Intestine Transplant Status/Complications.
Severity Level 5	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis.
Severity Level 5	Respirator Dependence/Tracheostomy Status.
Severity Level 5	Heart Assistive Device/Artificial Heart.

TABLE 6—HHS HCCS INCLUDED IN INFANT MODEL SEVERITY CATEGORIES—Continued

Severity Category	HCC
Severity Level 5	Heart Transplant.
Severity Level 5	Congestive Heart Failure.
Severity Level 5	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders.
Severity Level 5	Lung Transplant Status/Complications.
Severity Level 5	Kidney Transplant Status.
Severity Level 5	End Stage Renal Disease.
Severity Level 5	Stem Cell, Including Bone Marrow, Transplant Status/Complications.
Severity Level 4	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock.
Severity Level 4	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia.
Severity Level 4	Mucopolysaccharidosis.
Severity Level 4	Major Congenital Anomalies of Diaphragm, Abdominal Wall, and Esophagus, Age < 2.
Severity Level 4	Myelodysplastic Syndromes and Myelofibrosis.
Severity Level 4	Aplastic Anemia.
Severity Level 4	Combined and Other Severe Immunodeficiencies.
Severity Level 4	Traumatic Complete Lesion Cervical Spinal Cord.
Severity Level 4	Quadriplegia.
Severity Level 4	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease.
Severity Level 4	Quadriplegic Cerebral Palsy.
Severity Level 4	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy.
Severity Level 4	Non-Traumatic Coma, Brain Compression/Anoxic Damage.
Severity Level 4	Respiratory Arrest.
Severity Level 4	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes.
Severity Level 4	Acute Myocardial Infarction.
Severity Level 4	Heart Infection/Inflammation, Except Rheumatic.
Severity Level 4	Major Congenital Heart/Circulatory Disorders.
Severity Level 4	Intracranial Hemorrhage.
Severity Level 4	Ischemic or Unspecified Stroke.
Severity Level 4	Vascular Disease with Complications.
Severity Level 4	Pulmonary Embolism and Deep Vein Thrombosis.
Severity Level 4	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections.
Severity Level 4	Chronic Kidney Disease, Stage 5.
Severity Level 4	Hip Fractures and Pathological Vertebral or Humerus Fractures.
Severity Level 4	Artificial Openings for Feeding or Elimination.
Severity Level 3	HIV/AIDS.
Severity Level 3	Central Nervous System Infections, Except Viral Meningitis.
Severity Level 3	Opportunistic Infections.
Severity Level 3	Non-Hodgkin's Lymphomas and Other Cancers and Tumors.
Severity Level 3	Colorectal, Breast (Age < 50), Kidney and Other Cancers.
Severity Level 3	Breast (Age 50+), Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors.
Severity Level 3	Lipidoses and Glycogenosis.
Severity Level 3	Adrenal, Pituitary, and Other Significant Endocrine Disorders.
Severity Level 3	Acute Liver Failure/Disease, Including Neonatal Hepatitis.
Severity Level 3	Intestinal Obstruction.
Severity Level 3	Necrotizing Fasciitis.
Severity Level 3	Bone/Joint/Muscle Infections/Necrosis.
Severity Level 3	Osteogenesis Imperfecta and Other Osteodystrophies.
Severity Level 3	Cleft Lip/Cleft Palate.
Severity Level 3	Hemophilia.
Severity Level 3	Disorders of the Immune Mechanism.
Severity Level 3	Coagulation Defects and Other Specified Hematological Disorders.
Severity Level 3	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes.
Severity Level 3	Traumatic Complete Lesion Dorsal Spinal Cord.
Severity Level 3	Paraplegia.
Severity Level 3	Spinal Cord Disorders/Injuries.
Severity Level 3	Cerebral Palsy, Except Quadriplegic.
Severity Level 3	Muscular Dystrophy.
Severity Level 3	Parkinson's, Huntington's, and Spinocerebellar Disease, and Other Neurodegenerative Disorders.
Severity Level 3	Hydrocephalus.
Severity Level 3	Unstable Angina and Other Acute Ischemic Heart Disease.
Severity Level 3	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders.
Severity Level 3	Specified Heart Arrhythmias.
Severity Level 3	Cerebral Aneurysm and Arteriovenous Malformation.
Severity Level 3	Hemiplegia/Hemiparesis.
Severity Level 3	Cystic Fibrosis.
Severity Level 3	Fibrosis of Lung and Other Lung Disorders.
Severity Level 3	Pathological Fractures, Except of Vertebrae, Hip, or Humerus.

TABLE 6—HHS HCCS INCLUDED IN INFANT MODEL SEVERITY CATEGORIES—Continued

Severity Category	HCC
Severity Level 2	Viral or Unspecified Meningitis.
Severity Level 2	Thyroid, Melanoma, Neurofibromatosis, and Other Cancers and Tumors.
Severity Level 2	Diabetes with Acute Complications.
Severity Level 2	Diabetes with Chronic Complications.
Severity Level 2	Diabetes without Complication.
Severity Level 2	Protein-Calorie Malnutrition.
Severity Level 2	Congenital Metabolic Disorders, Not Elsewhere Classified.
Severity Level 2	Amyloidosis, Porphyria, and Other Metabolic Disorders.
Severity Level 2	Cirrhosis of Liver.
Severity Level 2	Chronic Pancreatitis.
Severity Level 2	Inflammatory Bowel Disease.
Severity Level 2	Rheumatoid Arthritis and Specified Autoimmune Disorders.
Severity Level 2	Systemic Lupus Erythematosus and Other Autoimmune Disorders.
Severity Level 2	Congenital/Developmental Skeletal and Connective Tissue Disorders.
Severity Level 2	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn.
Severity Level 2	Sickle Cell Anemia (Hb-SS).
Severity Level 2	Drug Psychosis.
Severity Level 2	Drug Dependence.
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes.
Severity Level 2	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies.
Severity Level 2	Seizure Disorders and Convulsions.
Severity Level 2	Monoplegia, Other Paralytic Syndromes.
Severity Level 2	Atherosclerosis of the Extremities with Ulceration or Gangrene.
Severity Level 2	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis.
Severity Level 2	Chronic Ulcer of Skin, Except Pressure.
Severity Level 1 (Lowest)	Chronic Hepatitis.
Severity Level 1	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption.
Severity Level 1	Thalassemia Major.
Severity Level 1	Autistic Disorder.
Severity Level 1	Pervasive Developmental Disorders, Except Autistic Disorder.
Severity Level 1	Multiple Sclerosis.
Severity Level 1	Asthma.
Severity Level 1	Chronic Kidney Disease, Severe (Stage 4).
Severity Level 1	Amputation Status, Lower Limb/Amputation Complications.
Severity Level 1	No Severity HCCs.

d. Cost-Sharing Reductions Adjustments (§ 153.320)

We proposed to continue including an adjustment for the receipt of cost-sharing reductions in the model to account for increased plan liability due to increased utilization of health care services by enrollees receiving cost-sharing reductions. The proposed cost-sharing reduction adjustment factors for 2017 risk adjustment are unchanged from those finalized in the 2016 Payment Notice and are set forth in Table 7. These adjustments are effective for 2015, 2016, and 2017 risk adjustment, and are multiplied against the sum of the demographic, diagnosis, and interaction factors. We will continue to evaluate this adjustment in future years as more data becomes available.

Comment: One commenter also recommended that HHS consider looking at other elements of adverse selection and induced demand within the individual market that are not currently captured in the risk adjustment model. Another commenter requested that if HHS were to operate risk adjustment in Massachusetts in 2017, HHS should include a cost-sharing reduction adjustment table that will account for the higher AVs of the ''Connector Care'' plans with wrap-around subsidies in Massachusetts.

Response: As we stated in the 2015 Payment Notice, in some States, expansion of Medicaid benefits under section 2001(a) of the Affordable Care Act may take the form of enrolling newly Medicaid-eligible enrollees into individual market plans. These enrollees could be placed into silver plan variations—either the 94 percent silver plan variation or the zero cost sharing plan variation—with a portion of the premiums and cost sharing paid for by Medicaid on their behalf. In Massachusetts, Connector Care plans represent these Medicaid alternative plans in the individual market. To address this induced utilization in the context of cost-sharing reduction plan variations in the HHS risk adjustment methodology, our methodology increases the risk score for individuals in these plan variations by the same factor that we use to adjust for induced utilization for individuals enrolled in cost-sharing plan variations to adjust for induced utilization for individuals enrolled in the corresponding Medicaid alternative plan variations. Here, those factors are both 1.12. We intend to evaluate these adjustments in the future after data from the initial years of risk adjustment is available. We are finalizing the cost-sharing reduction adjustment factors as proposed.

TABLE 7—COST-SHARING REDUCTION ADJUSTMENT

Household income	Plan AV	Induced utilization factor
Silver Plan Variant Recipients		
100–150% of FPL	Plan Variation 94%	1.12
150–200% of FPL	Plan Variation 87%	1.12
200–250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
Zero Cost-Sharing Recipients		
<300% of FPL	Platinum (90%)	1.00
<300% of FPL	Gold (80%)	1.07
<300% of FPL	Silver (70%)	1.12
<300% of FPL	Bronze (60%)	1.15
Limited Cost-Sharing Recipients		
>300% of FPL	Platinum (90%)	1.00
>300% of FPL	Gold (80%)	1.07
>300% of FPL	Silver (70%)	1.12
>300% of FPL	Bronze (60%)	1.15

e. Model Performance Statistics (§ 153.320)

To evaluate the model's performance, we examined its R-squared and predictive ratios. The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The predictive ratios measure the predictive accuracy of a model for different validation groups or subpopulations. The predictive ratio for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The predictive ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0. For each of the HHS risk adjustment models, the R-squared statistic and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.[11] Because we are blending, that is to mean, averaging, the coefficients from separately solved models based on MarketScan 2012, 2013, and 2014 data, we are publishing the R-squared statistic for each model and year separately to verify their statistical validity. The R-squared statistic for each model is shown in Table 8.

TABLE 8—R-SQUARED STATISTIC FOR HHS RISK ADJUSTMENT MODELS

Risk adjustment model	R-Squared statistic		
	2012	2013	2014
Platinum Adult	0.3905	0.3790	0.3610
Platinum Child	0.2669	0.2518	0.2341
Platinum Infant	0.2848	0.3223	0.3089
Gold Adult	0.3865	0.3746	0.3558
Gold Child	0.2621	0.2467	0.2288
Gold Infant	0.2826	0.3204	0.3069
Silver Adult	0.3828	0.3707	0.3512
Silver Child	0.2576	0.2422	0.2241
Silver Infant	0.2812	0.3191	0.3054
Bronze Adult	0.3808	0.3686	0.3488
Bronze Child	0.2554	0.2400	0.2218
Bronze Infant	0.2812	0.3190	0.3052
Catastrophic Adult	0.3807	0.3685	0.3488
Catastrophic Child	0.2554	0.2400	0.2218
Catastrophic Infant	0.2812	0.3190	0.3052

f. Overview of the Payment Transfer Formula (§ 153.320)

We did not propose to alter our payment transfer methodology. Plan average risk scores will continue to be calculated as the member month-weighted average of individual enrollee risk scores. We defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. In the 2014 Payment Notice, we combined those concepts into a risk adjustment payment transfer formula. Risk

[11] Winkleman, Ross and Syed Mehmud. ''A Comparative Analysis of Claims-Based Tools for Health Risk Assessment.'' Society of Actuaries (Apr. 2007), available at *https://www.soa.org/research/research-projects/health/hlth-risk-assement.aspx.*

adjustment transfers (payments and charges) will be calculated after issuers have completed risk adjustment data reporting. The payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (that is, HHS will calculate two separate transfer amounts for a plan that operates in two rating areas).

The payment transfer formula is designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula would be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

Comment: Commenters requested that administrative expenses be removed from the calculation of the statewide average premium. A commenter suggested that amending the transfer formula by eliminating administrative costs from the statewide average premium would make it ''benefit cost based.'' A commenter suggested that HHS consider basing the payment transfer on a portion of State average premium—namely, the portion representing the sum of claims, claims adjustment expenses, and taxes that are calculated on premium after risk adjustment transfers, by using a specified percentage of State average premiums. The commenter suggested the specified percentage could be determined based on data submitted by issuers on the Unified Rate Review Template (URRT) for the portion of premium needed for claims and on data from financial reporting statements for claim adjustment expenses and relevant taxes as a percent of premium and could vary by State or market. Some commenters opposed the use of the statewide average premium because it disadvantages issuers with below average premiums. Commenters requested that 2014 and later risk adjustment transfers for all plans with below average premiums in a State be calculated using the plans' own average premium amount or average claims cost, so that efficient plans are not penalized using the Statewide average premium. Commenters requested use of a ''care coordination factor'' in the risk transfer formula, and stated that risk adjustment results are distorted by regional biases, risks, and coding and demographic differences. One commenter recommended that risk scores be compared to other scores in the same geographic region, not to State averages, to avoid regional biases and to permit a fairer and more accurate comparison.

Response: We did not propose changes to the transfer formula, and therefore, are not addressing comments that are outside the scope of this rulemaking. We may be able to evaluate geographic differences in the future if we obtain enrollee-level data for future recalibrations—a topic that we also intend to discuss in the White Paper and at the March 31, 2016 risk adjustment conference.

(1) Overview of the Payment Transfer Formula

Although we did not propose to change the payment transfer formula from what was finalized in the 2014 Payment Notice (78 FR 15430 through 15434), we believe it is useful to republish the formula in its entirety, since, as noted above, we are recalibrating the HHS risk adjustment model. Transfers (payments and charges) will be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. As finalized in the 2014 Payment Notice, the HHS risk adjustment payment transfer formula is:

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \overline{P_s}$$

Where:

$\bar{P}_s$ = State average premium;
$PLRS_i$ = plan *i*'s plan liability risk score;
AV_i = plan *i*'s metal level AV;
ARF_i = allowable rating factor;
IDF_i = plan *i*'s induced demand factor;
GCF_i = plan *i*'s geographic cost factor;
s_i = plan *i*'s share of State enrollment.

The denominator is summed across all plans in the risk pool in the market in the State.

The difference between the two premium estimates in the payment transfer formula determines whether a plan pays a risk transfer charge or receives a risk transfer payment. Note that the value of the plan average risk score by itself does not determine whether a plan would be assessed a charge or receive a payment—even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating practices (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection. Risk adjustment transfers are calculated at the risk pool level, and catastrophic plans are treated as a separate risk pool for purposes of risk adjustment.

g. State-Submitted Alternate Risk Adjustment Methodology

We are not recertifying the alternate State methodology for use in Massachusetts for 2017 risk adjustment. Massachusetts and HHS will begin the transition that will allow HHS to operate risk adjustment in Massachusetts in 2017. HHS will operate risk adjustment in all States for the 2017 benefit year.

h. Risk Adjustment User Fee (§ 153.610(f))

As noted above, if a State is not approved to operate or chooses to forgo operating its own risk adjustment program, HHS will operate risk adjustment on the State's behalf. As described in the 2014 Payment Notice, HHS's operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that an issuer of a risk adjustment covered plan with the meaning of § 153.20 must remit a user fee to HHS equal to the product of its monthly enrollment in the plan and the per enrollee per month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. The risk adjustment program will provide special benefits as defined in section 6(a)(1)(b) of Circular No. A–25R to issuers of risk adjustment covered plans because it will mitigate the financial instability associated with potential adverse risk selection. The risk adjustment program also will contribute to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual and small group health insurance markets.

In the 2016 Payment Notice, we estimated Federal administrative

expenses of operating the risk adjustment program to be $1.75 per enrollee per year, based on our estimated contract costs for risk adjustment operations. For the 2017 benefit year, we proposed to use the same methodology to estimate our administrative expenses to operate the program. These contracts cover development of the model and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. To calculate the user fee, we divided HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of enrollees in risk adjustment covered plans (other than plans not subject to market reforms and student health plans, which are not subject to payments and charges under the risk adjustment methodology HHS uses when it operates risk adjustment on behalf of a State) in HHS-operated risk adjustment programs for the benefit year.

We estimated that the total cost for HHS to operate the risk adjustment program on behalf of States for 2017 would be approximately $52 million, and that the risk adjustment user fee would be $1.80 per enrollee per year. We stated that the risk adjustment user fee contract costs for 2017 include costs related to 2017 risk adjustment data validation, and are slightly higher than the 2016 contract costs because some contracts were rebid. We do not anticipate that Massachusetts' decision to use the Federal risk adjustment methodology will substantially affect the risk adjustment user fee rate for 2017.

Comment: One commenter strongly supported the assessment of a higher risk adjustment user fee to support the RADV program. Another commenter requested transparency for the user fee rate and that HHS consider less costly alternatives. One commenter expressed concern over the risk adjustment user fee proposal since HHS collected increased user fees accounting for 2014 risk adjustment data validation in 2016 but delayed 2014 risk adjustment data validation. This commenter recommended that HHS use those increased fees to pay for risk adjustment data validation in 2017 and decline to increase user fees for 2017 risk adjustment.

Response: In response to the comment regarding risk adjustment data validation costs, we re-examined all assumptions that went into the calculation of the risk adjustment user fee. First, we determined that our expected contract costs for 2017 risk adjustment are lower than anticipated, currently estimated at approximately $24 million. Then, we looked at the enrollment assumptions we were using to calculate the previous benefit year user fees. Because we now have actual 2014 risk adjustment enrollment, we were able to base expected 2017 enrollment on projected member month enrollment rather than total enrollees. We are revising the risk adjustment user fee to reflect lower contract costs for the 2017 benefit year and more accurate enrollment projections. Therefore, we are finalizing the 2017 risk adjustment user fee at $1.56 per enrollee per year, or $0.13 PMPM.

3. Provisions and Parameters for the Transitional Reinsurance Program

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In the 2014 Payment Notice, we expanded on the standards set forth in subparts C and E of the Premium Stabilization Rule and established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2014 benefit year. In the 2015 Payment Notice, we established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2015 benefit year and certain oversight provisions related to the operation of the reinsurance program. In the 2016 Payment Notice, we established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2016 benefit year and certain clarifying provisions related to the operation of the reinsurance program.

a. Decreasing the Reinsurance Attachment Point for the 2016 Benefit Year

Section 1341(b)(2)(B) of the Affordable Care Act directs the Secretary, in establishing standards for the transitional reinsurance program, to include a formula for determining the amount of reinsurance payments to be made to non-grandfathered, individual market issuers for high-risk claims that provides for the equitable allocation of funds. In the Premium Stabilization Rule (77 FR 17228), we provided that reinsurance payments to issuers of reinsurance-eligible plans will be made for a portion of an enrollee's claims costs paid by the issuer (the coinsurance rate) that exceeds an attachment point (when reinsurance would begin), subject to a reinsurance cap (when the reinsurance program stops paying claims for a high-cost individual). The coinsurance rate, attachment point, and reinsurance cap together constitute the uniform reinsurance payment parameters.

We provided in the 2015 Payment Notice (79 FR 13777) that HHS will use any excess contributions for reinsurance payments for a benefit year by increasing the coinsurance rate for that benefit year up to 100 percent before rolling over any remaining funds in the next year. In the proposed rule, we proposed that if any contribution amounts remain after calculating reinsurance payments for the 2016 benefit year (and after HHS increases the coinsurance rate to 100 percent for the 2016 benefit year), HHS would decrease the 2016 attachment point of $90,000 to pay out any remaining contribution amounts to issuers of reinsurance-eligible plans in an equitable manner for the 2016 benefit year.

We received numerous comments in support of this proposal and are finalizing this provision as proposed.

Comment: One commenter stated that changing the reinsurance payment parameters at the end of the program—instead of identifying and updating the parameters in earlier benefit years as current information is available—would be disruptive. The commenter stated that this proposal would cause disruption for States that exercised the option to create supplemental reinsurance programs and that need to set uniform reinsurance payment parameters.

Response: The final 2016 reinsurance coinsurance rate and attachment point, which would reflect a potential increase in coinsurance rate from 50 to 100 percent and a potential decrease in the attachment point from $90,000 to an amount that pays out remaining contributions in an equitable manner, will not be set until HHS confirms the total amount of contributions available and reinsurance payment requests for the 2016 benefit year. HHS understands that no State-operated reinsurance program established supplemental reinsurance payment parameters under §§ 153.220(d) and 153.232 and therefore no States will be affected by this provision. We believe that expending all remaining reinsurance contribution funds as payments for the 2016 benefit year will support the reinsurance program's goals of promoting nationwide premium stabilization and market stability in the early years of Exchange operations while providing issuers with incentives to continue to effectively manage enrollee costs.

Comment: One commenter asked that HHS use excess reinsurance contributions to fund the deficit in the risk corridors program.

Response: Section 1341 of the Affordable Care Act establishes the transitional reinsurance program to compensate non-grandfathered individual market plans for high-cost enrollees in the initial years of the Exchange. We believe that our policy to expend any remaining reinsurance contribution funds as reinsurance payments for the 2016 benefit best aligns with that statutory purpose.

b. Audit Authority Extends to Entities That Assist Contributing Entities (§ 153.405(i))

In accordance with § 153.405(i), HHS or its designee has the authority to audit a contributing entity to assess compliance with the reinsurance program requirements. In 2014, HHS implemented a streamlined approach through which a contributing entity, or a third party such as a third party administrator or an administrative services-only contractor acting on behalf of a contributing entity, could register on Pay.gov, calculate the annual enrollment count and schedule reinsurance contribution payments. During the 2014 and 2015 contribution submission process, many third party administrators and administrative services-only contractors assisted contributing entities by calculating the contributing entity's annual enrollment count and maintaining the records necessary to validate that enrollment. In the proposed rule, we proposed to amend § 153.405(i) to specify that the audit authority extends to any third party administrators, administrative services-only contractors, or other third parties that complete any part of the reinsurance contribution submission process on behalf of contributing entities or otherwise assist contributing entities with compliance with the requirements for the transitional reinsurance program. Additionally, we proposed to amend § 153.405(i) to specify that a contributing entity that chooses to use a third party administrator, administrative services-only contractor, or other third party to assist with its obligations under the reinsurance program must ensure that this third party administrator, administrative services-only contractor, or other third party cooperate with any audit under this section.

After reviewing the comments received on this proposal, we will not finalize our amendment to § 153.405(i) that extended the audit authority to third party administrators, administrative services-only contractors or other third parties that assist a contributing entity with compliance with reinsurance program requirements. However, HHS will finalize as proposed the amendment to § 153.405(i) specifying that a contributing entity that chooses to use a third party administrator, administrative services-only contractor, or other third party to assist with its obligations under the reinsurance program must ensure that this third party administrator, administrative services-only contractor, or other third party cooperates with any audit under that section. We note that under § 153.405(i) HHS, or its designee, has the authority to audit contributing entities' compliance with their obligations under the reinsurance program.

Comment: One commenter disagreed with HHS's proposal to extend the audit authority to third party administrators, administrative services-only contractors, or other third parties, arguing that it was unnecessary and would increase the costs of compliance.

Response: We recognize the commenter's concerns about increasing compliance costs, and are not finalizing our proposal to extend the audit authority. However, a contributing entity that uses a third party administrator, administrative services-only contractor, or other third party to assist with its obligations under the reinsurance program must ensure that such organization cooperates with any audit of the contributing entity under this section.

4. Provisions for the Temporary Risk Corridors Program

This section contains proposals related to the temporary risk corridors program, and therefore applies only to issuers of QHPs, as defined at § 153.500, with respect to the benefit years 2014 through 2016.

a. Risk Corridors Payment Methodology (§ 153.510(g))

To ensure the integrity of data used in risk corridors and MLR calculations, in prior guidance we indicated that we would propose in the HHS Notice of Benefit and Payment Parameters for 2017 an adjustment to correct for any inaccuracies in risk corridors payment and charge amounts that could result from issuers reporting a certified estimate of cost-sharing reductions on the 2014 MLR and Risk Corridors Annual Reporting Form.[12] The use of a certified estimate that is lower than the actual cost-sharing reductions provided would affect the MLR calculation and the risk corridors financial transfers by increasing incurred claims and allowable costs, thereby increasing the MLR and potentially increasing the risk corridors payment or lowering the risk corridors charge. We believe that requiring an update of these reported amounts through recalculation of the risk corridors and MLR amounts for the 2014 benefit year will be disruptive to the market and consumers, as well as administratively burdensome and difficult to operationalize for issuers and HHS. Therefore, consistent with our earlier guidance, we proposed to add a new paragraph (g) to the risk corridors payment methodology set forth in § 153.510 stating that if the issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual cost-sharing reductions provided (as calculated under § 156.430(c) for the 2014 benefit year, which will take place in the spring of 2016), HHS would make an adjustment to the amount of the issuer's 2015 benefit year risk corridors payment or charge measured by the full difference between the certified estimate reported and the actual cost-sharing reductions provided as calculated under § 156.430(c) in order to address the impact of the inaccurate reporting on the risk corridors and MLR calculations for the 2014 benefit year. We are finalizing this policy and the amendment to § 153.510(g) as proposed.

Comment: Several commenters recommended that, to the extent the certified estimate of cost-sharing reductions reported on the 2014 MLR and Risk Corridors Annual Reporting Form is lower than the actual cost-sharing reductions provided, the difference should be reflected as an adjustment to the cost-sharing reduction amount reported for the 2015 benefit year rather than the risk corridors payment or charge.

Response: We note that we are also amending § 153.710(g) (see III.D.5.d of this preamble) to require that issuers adjust the cost-sharing reduction amount reported for the 2015 benefit year to account for the difference between cost-sharing reduction amounts reported for the 2014 benefit year and actual cost-sharing reduction amounts as determined under § 156.430(c). The separate, direct adjustment to the 2015 risk corridors payment or charge set

[12] Cost-Sharing Reduction Amounts in Risk Corridors and Medical Loss Ratio Reporting (Jun. 19, 2015), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Advance-CSR-Payment-and-RC-MLR-submission_6192015.pdf.*

forth in § 153.510(g) was intended as a program integrity measure, to help ensure that issuers did not report certified estimates of cost-sharing reduction amounts for the 2014 benefit year that they knew would likely be lower than their advance payment amounts.

b. Risk Corridors Data Requirements (§ 153.530)

In the proposed rule (80 FR 75488), we proposed to amend § 153.530 to require that for the 2015 and later benefit years, issuers must true up their claims liabilities and reserve amounts that were used to determine their allowable costs reported for the risk corridors program for the preceding benefit year to reflect the actual claims payments made through June 30 of the year following the benefit year. We also requested comments on how to handle the true-up of unpaid claims estimates for 2016, suggesting four alternatives: provide for a 2017 payment or charge; provide for a simplified true-up process; require that the 2016 estimate be based on actual 2014 and 2015 amounts; or provide for no true-up in the final year.

Comment: One commenter supported our proposal. Several commenters opposed our proposal, noting that any improvement in the accuracy of risk corridor payments to issuers under the proposal would be outweighed by the administrative burden on issuers, and minimized by the operational mechanics of the risk corridor program and the potential for continued shortfall in the program. However, most of these commenters were primarily concerned with our proposal to require claims valuation at June 30 rather than March 31, and not with the proposal to true-up claims estimates. Other commenters opposed only the true-up of 2016 unpaid claims estimates, and additionally expressed concern that 2014 and 2015 claims experience may not accurately reflect 2016 experience.

Response: We acknowledge commenters' concern regarding the potential lack of practical advantages of requiring claims valuation at June 30 rather than March 31 and requiring a true-up of 2016 unpaid claims estimates. However, we continue to believe that a true-up of 2014 and 2015 unpaid claims estimates is important to preserve the integrity of the risk corridors program. Therefore, we are finalizing the amendment adding § 153.530(b)(2)(iv) as proposed with respect to the true-up of 2014 and 2015 experience in the reporting for the 2015 and 2016 benefit years. We will address the true-up of 2016 experience after we have evaluated the results of the true-up of 2014 experience.

5. Distributed Data Collection for the HHS-Operated Programs

a. Interim Dedicated Distributed Data Environment Reports (§ 153.710(d))

In the proposed rule, we proposed deleting § 153.710(d), which sets forth an interim discrepancy reporting process by which an issuer must notify HHS of any discrepancy it identifies between the data to which the issuer has provided access to HHS through its dedicated distributed data environment (that is, an issuer's EDGE server) and the interim dedicated distributed data environment report (that is, an issuer's interim EDGE report), or confirm to HHS that the information in the interim report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the timeframe specified in the report. We proposed that this change would be effective beginning with the 2016 benefit year.[13]

We received numerous comments in support of this proposal, and are finalizing this provision as proposed. We also finalize our proposal to remove any cross-references in §§ 153.710 and 156.1220 to the interim discrepancy reporting process currently codified at § 153.710(d) and conforming amendments to redesignate paragraph (e) as paragraph (d), as well as to revise and redesignate paragraph (f) as (e).

Comment: Some commenters asked that HHS confirm that there will continue to be a robust process to allow issuers to identify and resolve potential discrepancies throughout the data submission process.

Response: HHS is committed to working with issuers prior to the data submission deadline to address any data issues so that reinsurance payment and risk adjustment transfer calculations can be made accurately and timely. Throughout the data collection period, HHS will continue to maintain a help desk, host user group calls and webinars, and make reports available to issuers on their respective EDGE servers to assist issuers with the identification and resolution of data submission errors and to provide technical assistance.

Comment: One commenter asked that HHS allow issuers 30 days to respond to the final dedicated distributed data environment report with any discrepancies, rather than the 15-calendar-day timeframe set forth in § 153.710(e) (now finalized as § 153.710(d)).

Response: HHS will continue to require issuers to respond within 15 calendar days to the final dedicated distributed data environment report. As we explained in the 2015 Payment Notice final rule (79 FR 13790), the 15-calendar day reporting timeframe for the final dedicated distributed data environment report is necessary so that HHS can notify issuers of their risk adjustment payment or charge and total estimated reinsurance payments by June 30 of the year following the applicable benefit year, as required under §§ 153.310(e) and 153.240(b)(1)(ii).

Comment: One commenter asked HHS to release guidance on the 2015 discrepancy reporting process in early January.

Response: HHS intends to issue future guidance on the final discrepancy reporting process set forth in § 153.710(e) (now finalized as § 153.710(d)) prior to the final discrepancy reporting window.

b. Risk Adjustment Interim Reports

We did not propose any provisions related to risk adjustment interim reports in the Payment Notice. However, we received a number of comments related to the schedule of risk adjustment reports and the availability of additional information prior to the final summary report on June 30 of the year following the applicable benefit year.

Comment: Several commenters requested that HHS issue the summary report earlier than June 30. Commenters also requested interim or quarterly reports so that issuers could incorporate improved estimates into rate setting. Commenters suggested HHS provide interim reports with issuers' calculated risk scores, market-wide risk scores, and the other components of the payment transfer formula, including the Statewide average premium. Commenters also recommended that HHS disclose any issues with the completeness of data in the report so that issuers can take this into account when reviewing results. Commenters further suggested that HHS may want to consider publishing additional details such as the issuer's market share, market average distribution by metal plan, market allowable rating factor, and market proportion of claims with HCCs.

[13] For the 2015 benefit year, issuers are not required to confirm that the information in the interim report accurately reflects the reinsurance and risk adjustment data to which the issuer has provided access through its EDGE server; or describe any discrepancy an issuer identifies in the interim report. See FAQ 14247 (Dec. 15, 2015), available at *www.regtap.info*.

Response: We issued an FAQ on January 8, 2016 [14] stating that we will release an interim public summary report in March 2016 for those States and risk pools where the risk adjustment data that has been submitted by February 1, 2016 meets HHS's data sufficiency thresholds. The interim summary report will include the following transfer formula elements by State and risk pool: (1) Average monthly premiums; (2) average plan liability risk score; (3) average allowable rating factor; (4) average actuarial value; (5) billable member months; and (6) geographic cost factors. We will also provide issuers with an interim report that contains their own issuer-specific information and that will not be released publicly. We are providing this information because issuers have indicated that, taken in concert with other data available to them, it may help them formulate more accurate estimates of their risk adjustment transfers. However, we continue to caution that data provided in these interim reports will be preliminary, do not represent any determination by HHS regarding the credibility of the data submitted, and that final risk adjustment results may be substantially different.

c. Evaluation of Quality and Quantity of EDGE Data Submissions (§ 153.710(f))

Under § 153.740(b), if an issuer of a risk adjustment covered plan fails to provide HHS with access to the required data in a dedicated distributed data environment such that HHS cannot apply the applicable Federally certified risk adjustment methodology to calculate the risk adjustment payment transfer amount for the risk adjustment covered plan in a timely fashion, HHS will assess a default risk adjustment charge. Similarly, under §§ 153.420 and 153.740(a), an issuer of a reinsurance-eligible plan will forfeit reinsurance payments it otherwise might have received if the issuer fails to establish a dedicated distributed data environment or fails to meet the data requirements set forth in §§ 153.420 and 153.700 through 153.730. On April 24, 2015, HHS released guidance entitled ''Evaluation of EDGE Data Submissions'' describing the approach it would use to evaluate whether the quality and quantity of the data that an issuer provided to a dedicated distributed data environment was sufficient for HHS to calculate reinsurance payments and apply the HHS risk adjustment methodology for the 2014 benefit year.[15] In the proposed rule, we proposed to codify this practice for future benefit years to support the integrity of payments and charges under the HHS-operated risk adjustment program and payments under the reinsurance program, both of which depend upon the submission of accurate and complete by issuers.

Consistent with the approach for review of 2014 benefit year data, to determine if an issuer meets *data quantity* standards, we proposed that HHS would compare an issuer's self-reported baseline data of total enrollment and claims counts by market to the data submitted to the issuer's dedicated distributed data environment. An issuer whose total enrollment counts were lower than its baseline data submission by the deadline for submitting data to the dedicated distributed data environment would be subject to a default risk adjustment charge under § 153.740(b). An issuer whose total claims counts were lower than its baseline data submission by the deadline for submitting data to the dedicated distributed data environment would be subject to a default risk adjustment charge only if the default charge was lower than the charge it would have received through the risk adjustment transfer calculation. Additionally, an issuer with either a low enrollment count or a low claims count following the final data submission deadline would forgo reinsurance payments for any claims that it failed to submit. In the proposed rule, HHS stated that it would set forth in guidance, on an annual basis, the appropriate threshold by which HHS will deem data sufficient as to quantity for a given benefit year.[16] We also stated that HHS would also specify in guidance the format and timeline for submission of baseline data to HHS.[17]

To determine if an issuer meets the *data quality* standards required for HHS to calculate reinsurance payments and apply the HHS risk adjustment methodology, HHS proposed to perform an outlier analysis using select metrics that target reinsurance data quality and risk adjustment data quality.[18] As with our data quantity metrics, HHS plans to describe in guidance, on an annual basis, the metrics used for a given benefit year.[19] An issuer may be assessed a risk adjustment default charge if it does not meet data quality standards on any of the risk adjustment metrics, and may forfeit reinsurance payments it might otherwise have received if it does not meet data quality standards for any of the reinsurance metrics.

HHS would conduct these data quantity and quality analyses after the deadline for submission of data specified in § 153.730 (that is, April 30, of the year following the applicable benefit year).[20] We proposed to add a new paragraph (f) to § 153.710 to specify that HHS will assess default risk adjustment charges based on these analyses no later than the date of the notification provided by HHS under § 153.310(e) (that is, June 30 of the year following the applicable benefit year); and to describe the responsibilities of issuers in relation to the quantity and quality analyses. In § 153.710(f)(1), we proposed to codify the requirement for issuers to provide baseline data on their total enrollment and claims counts by market, in a format and on a timeline specified by HHS in guidance. In § 153.710(f)(2), we proposed that if HHS identifies a data outlier that would cause the data that a risk adjustment covered plan or a reinsurance-eligible plan made available through a dedicated distributed data environment to fail HHS's quality thresholds, the issuer may, within 10 calendar days of receiving notification of the outlier,

[14] See FAQ 14572, (Jan. 8, 2016), available at *https://www.regtap.info/.*

[15] EDGE Server Data Bulletin—INFORMATION; Evaluation of EDGE Data Submissions (Apr. 24, 2015), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-guidance-42415-final.pdf.*

[16] For information on the data quantity thresholds that will be used to evaluate issuer's EDGE server data for the 2015 benefit year related to the release of interim reinsurance payments and interim risk adjustment summary reports, see EDGE Server Data Bulletin—INFORMATION; Evaluation of EDGE Data Submissions for 2015 Benefit Year for Interim Reinsurance Payment and Interim Risk Adjustment Summary Report (Jan. 20, 2016), available at *https://www.regtap.info/uploads/library/EDGEServer_DataBulletin_5CR_012016.pdf.* Guidance on the on-going and final quantity evaluation processes will be released in the near future.

[17] *Ibid.*

[18] For the 2014 benefit year, HHS used the following five key metrics: Percentage of all enrollees with at least one HCC; average number of conditions per enrollee with at least one HCC; issuer average risk score; percentage of individual market enrollees with reinsurance payments; and average reinsurance payment per enrollee for which the issuer would receive reinsurance payments.

[19] For information on the data quality thresholds that will be used to evaluate issuer's EDGE server data for the 2015 benefit year related to the release of interim reinsurance payments and interim risk adjustment summary reports, see EDGE Server Data Bulletin—INFORMATION; Evaluation of EDGE Data Submissions for 2015 Benefit Year for Interim Reinsurance Payment and Interim Risk Adjustment Summary Report (Jan. 20, 2016), available at *https://www.regtap.info/uploads/library/EDGEServer_DataBulletin_5CR_012016.pdf.* Guidance on the on-going and final quantity evaluation processes will be released in the near future.

[20] For the 2015 benefit year, the data submission deadline is Monday, May 2, 2016 because April 30, 2016 is a Sunday. See FAQ 14472, (Dec. 21, 2015), available at *https://www.regtap.info.*

submit a justification of the outlier for HHS to consider in determining whether the issuer met the reinsurance and risk adjustment data requirements.

We indicated that HHS expects to perform informal data quantity and quality analyses throughout the data submission process, providing issuers with time to address any outlier before the data submission deadline. Issuers may provide justifications of data outliers, updates to their respective EDGE server data, and corrected baseline enrollment or claims counts at any time during the data submission process, and are encouraged to do so as early as possible. The timeframe we proposed in § 153.710(f)(2) would apply to the final data quantity and quality analyses only, which are performed following the deadline for submission of data specified in § 153.730 (that is, April 30, of the year following the applicable benefit year).

We are finalizing these provisions as proposed, with two modifications. In § 153.710(f), we are removing the proposed language that set forth a time limitation for HHS to assess a default risk adjustment charge based on the data quantity and quality analyses because the administrative appeals process set forth in § 156.1220 could result in imposition of a default risk adjustment charge. For example, if we determine during the administrative appeals process that a data submission error was of such magnitude that the issuer did not meet the data quantity and quality thresholds set forth for that benefit year, then we may assess a default risk adjustment charge if that charge is lower than the charge the issuer is being assessed for that benefit year. We also changed the heading for § 153.710(f) from ''Data Sufficiency'' to ''Evaluation of Dedicated Distributed Data.''

Comment: Numerous commenters asked that HHS extend the 10-day deadline to submit an explanation of the outlier to HHS. Several commenters asked that HHS provide issuers 15 days or 30 days to respond. One commenter agreed with the 10-day deadline.

Response: The 10-day deadline only applies when HHS conducts the final quality and quantity analyses of the data submitted to an issuer's dedicated distributed data environment, which are performed following the deadline for submission of data specified in § 153.730 (that is, April 30 of the year following the applicable benefit year). As noted above, HHS will continuously analyze the quantity and quality of an issuer's data, providing reports and notices to issuers and allowing time to correct any outliers during the data submission window. The 10-day deadline is necessary because HHS must review an issuer's outlier justification to calculate reinsurance payments and apply the HHS risk adjustment methodology by the June 30 notification.

Comment: Some commenters asked that the data quantity and quality analysis prior to the data submission deadline for an applicable benefit year be robust and that HHS quickly respond to issuers to allow them to identify and resolve issues during the data submission process.

Response: HHS will perform informal data quantity and quality analyses throughout the data submission process, providing issuers with reports and notices to allow time to address any outliers before the data submission deadline. HHS encourages issuers to work with HHS any time an issue or problem is encountered. Issuers may provide justifications, update their EDGE server data, and correct baseline enrollment or claims counts at any time during the data submission process, and are encouraged to do so as early as possible.

Comment: One commenter recommended that HHS provide full transparency into the evaluation process, including with respect to how HHS intends to apply its measurements for baseline data and quality. Another commenter asked that HHS publish the timeframes for the data quantity and quality analysis in the annual Letter to Issuers.

Response: HHS strives to be transparent with respect to these processes, and will issue guidance regarding the data quantity and quality process and timeframes. See *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html* or *http://www.regtap.info/.*

Comment: One commenter urged HHS to publish the timeline and format for submission of baseline data as soon as possible prior to the applicable benefit year.

Response: HHS will continue to publish timeframe and guidance materials related to the baseline submission process as soon as practicable. HHS has already released guidance regarding the submission of baseline data for the 2015 benefit year.[21]

Comment: One commenter requested that HHS establish an appeals process for issuers whose data is determined to fail the data quantity and quality standards.

Response: As we stated in the proposed rule in the preamble section to § 156.1220, an issuer may file a request for reconsideration if it believes that HHS made a processing error, incorrectly applied its methodology, or made a mathematical error related to the data quantity and quality standards. For example, an issuer may file a request for reconsideration to challenge the assessment of a default risk adjustment charge if the issuer believes the default charge was assessed because HHS incorrectly applied its methodology regarding data quantity and quality standards. We note that, under § 156.1220(a)(4)(ii), a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under § 153.710(d)(2), it was identified and remains unresolved.

d. Data Requirements (§ 153.710(g))

We proposed revising § 153.710(g)(1)(iii) to require an issuer to report the amount of cost-sharing reductions calculated under § 156.430(c) in its annual MLR and risk corridors report, regardless of whether the issuer had any unresolved discrepancy under § 156.1210, or whether the issuer had submitted a request for reconsideration under § 156.1220(a)(1)(v). Additionally, consistent with the process outlined in § 153.710(g)(2), we proposed to require an issuer to adjust the cost-sharing reduction amount it reports on its 2015 risk corridors and MLR forms by the difference (if any) between the reported cost-sharing reduction amount used to adjust allowable costs and incurred claims on the 2014 MLR Annual Reporting Form and the amount of cost-sharing reductions as calculated under § 156.430(c) for the 2014 benefit year.

Consistent with the approach currently outlined in § 153.710(g)(2), we proposed to amend this paragraph to require an issuer to report any adjustment made or approved by HHS for any risk adjustment payment or charge, reinsurance payment, cost-sharing reduction payment to reflect actual cost-sharing reduction amounts received, or risk corridors payment or charge, where the adjustment has not been accounted for in a prior MLR and Risk Corridors Annual Reporting Form in the next following year. For example, if an issuer's risk adjustment charges or payments are adjusted as a result of the administrative appeals process, the issuer should adjust these reported amounts in the next MLR and risk corridors reporting cycle, after the

[21] 2015 EDGE Server Status and Baseline Reporting (Oct, 20, 2015), available at *https://www.regtap.info/reg_library.php?libfilter_topic=3.*

appeal has been resolved. Similarly, if HHS makes changes to an issuer's risk adjustment charges or payments after the risk corridors and MLR reporting cycle has closed for the applicable reporting year, the issuer should adjust these reported amounts in the next MLR and risk corridors reporting cycle to account for the difference between the reported amounts and the amounts actually received or paid for the previous benefit year. However, if an issuer is notified about the modification during an open MLR and risk corridors submission period, it must report the modified amounts in that open reporting cycle.

We also proposed to clarify in § 153.710(g)(1)(iii) that cost-sharing reduction amounts to be reported under this section must exclude amounts reimbursed to providers of services or items. This clarifying language is consistent with how the instructions for cost-sharing reductions amounts are reported under §§ 153.530(b)(2)(iii) (risk corridors data requirements) and 158.140(b)(iii) (MLR data requirements).

We also proposed to revise paragraph (g)(1)(iv) to require that for medical loss ratio reporting only, issuers should report the risk corridors payment to be made or charge assessed by HHS, as reflected under § 153.510. Lastly, HHS learned in the first year of implementation of the premium stabilization and Exchange financial assistance programs that some flexibility is needed when reporting these program amounts for purposes of risk corridors and MLR reporting. As such, we proposed in § 153.710(g)(3) that HHS have the ability to modify the reporting instructions set forth in § 153.710(g)(1) and (2) through guidance. Our intent in issuing any such guidance would be to avoid having the application of the reporting instructions lead to unfair or misleading financial reporting in exceptional circumstances.

Based on comments received, we are finalizing these provisions as proposed, with one modification. We are modifying § 153.710(g)(2) to specify that an issuer must report any adjustment made or approved by HHS by August 15, or the next applicable business day, of the reporting year for any risk adjustment payment or charge, including an assessment of risk adjustment user fees; any reinsurance payment; any cost-sharing reduction payment or charge; or any risk corridors payment or charge, in the current MLR and risk corridors reporting year, unless the adjustment meets the criteria for a ''de minimis'' change outlined in prior guidance.[22] HHS will also finalize as proposed the conforming amendments to the introductory language at § 153.710(g)(1) to remove the cross-references to the interim discrepancy reporting process currently codified at § 153.710(d). See III.D.5.a of this preamble for a discussion of the conforming amendments related to the removal of interim discrepancy reporting process.

Comment: One commenter agreed with the proposal to require an issuer to report any adjustment made or approved by HHS for any risk adjustment payment or charge, reinsurance payment, cost-sharing reduction payment to reflect actual cost-sharing reduction amounts received, or risk corridors payment or charge, where the adjustment has not been accounted for in a prior MLR and Risk Corridors Annual Reporting Form, in the following year, but further recommended that we establish a cut-off date for notifications of adjustments of June 30, after which adjustments must be reported in the following year's MLR and risk corridors reporting cycle. The commenter suggested that notifications by June 30 would give issuers sufficient time to incorporate data changes into their MLR and risk corridors submissions by the July 31 reporting deadline.

Response: We recognize that, in some cases, the timing of notifications of changes to data such as risk adjustment charges or payments may affect an issuer's MLR and risk corridors submission. Issuers must adhere to the July 31 regulatory deadline for submitting MLR and risk corridors data for the preceding benefit year. In order to accommodate potential adjustments to reinsurance payments, risk adjustment payments or charges, or payments or charges resulting from the cost-sharing reduction reconciliation process, in the period immediately after the issuance of the June 30 report while also maintaining the accuracy of issuers' MLR and risk corridors submissions, we are modifying § 153.710(g)(2) to specify that if HHS notifies an issuer about an adjustment by August 15, the issuer must report the adjustment in the current year reporting cycle, unless the adjustment meets the criteria for a ''de minimis'' change outlined in prior guidance.[23] We note that we expect only a small number of issuers to be required to resubmit data due to such an adjustment, and that all issuers should prepare to disburse rebates by the September 30 deadline. For those issuers who may be notified an adjustment that does not meet the ''de minimis'' criteria by August 15, HHS will work with the issuer to facilitate resubmission of its MLR and risk corridors submissions and to address the impact on MLR rebates, if necessary, in a manner that limits additional operational burden for the issuer.

Comment: One commenter asked that HHS not finalize § 153.710(g)(1)(iii), stating this change would limit the ability of issuers with alternative payment models to receive cost-sharing reduction amounts for capitated payment arrangements.

Response: The language under § 153.710(g)(1)(iii) does not limit the ability of issuers with alternative payment arrangements to receive cost-sharing reduction payments, and is consistent with other cost-sharing reduction reporting requirements, for example, allowable costs under § 153.530(b)(2)(iii) (risk corridors data requirements) must be reduced by the amount of cost-sharing reduction payments received by the issuer, except for, or excluding, any part of those payments used by the issuer to reimburse providers.

e. Good Faith Safe Harbor

In the second Program Integrity Rule, we finalized § 153.740(a), which permits HHS to impose civil money penalties upon issuers of risk adjustment covered plans and reinsurance-eligible plans for failure to adhere to certain standards relating to their dedicated distributed data environments. In the proposed rule, consistent with our previous statements in the 2016 Payment Notice (80 FR 10780), we stated that we would not be extending the good-faith safe harbor to 2016. Starting in the 2016 calendar year and beyond, civil money penalties may be imposed if an issuer of a risk adjustment covered plan or reinsurance-eligible plan fails to establish a dedicated distributed data environment in a manner and timeframe specified by HHS; fails to provide HHS with access to the required data in such environment in accordance with § 153.700(a) or otherwise fails to comply with the requirements of §§ 153.700 through 153.730; fails to adhere to the reinsurance data submission requirements set forth in § 153.420; or fails to adhere to the risk adjustment data submission and data storage requirements set forth in §§ 153.610 through 153.630, even if the issuer has made good faith efforts to comply with

[22] Risk Corridors and Medical Loss Ratio (MLR) Resubmissions for the 2014 Benefit Year, (Aug. 14, 2015), available at *https://www.regtap.info/uploads/library/RC_MLR_ResubmissionFAQ_5CR_081415.pdf.*

[23] *https://www.regtap.info/uploads/library/RC_MLR_ResubmissionFAQ_5CR_081415.pdf.*

these requirements. This safe harbor provision parallels a similar safe harbor for QHP issuers in FFEs under § 156.800 that also expired at the end of the 2015 calendar year. See III.G.7 of this preamble for the accompanying discussion of the safe harbor provision under § 156.800. However, we are clarifying that HHS will not impose civil money penalties under § 153.740(a) in 2016 or later based on activities that occurred in the 2014 or 2015 calendar year if the issuer acted in good faith at that time.

Comment: Several commenters asked HHS to extend the good faith safe harbor to 2016, while others supported our proposal. Some commenters asked that HHS allow a good faith safe harbor for all new processes, such as policy-based payments and reconciliation of advance payments of cost-sharing reductions.

Response: HHS will not extend the good faith safe harbor to cover conduct in 2016 or later years (including with respect to activities that occur in the 2016 calendar year or later relating to data from earlier benefit years). We believe that the 2 calendar years that we provided under this policy were sufficient to permit issuers to transition into compliance with the applicable risk adjustment, reinsurance and distributed data collection requirements. Of course, in all our enforcement actions, we will continue to take into account all facts and circumstances, including the reasonable good faith action of issuers.

Comment: A few commenters asked that HHS make clear that the good faith safe harbor continues to apply to conduct for benefit years prior to 2016 in perpetuity.

Response: HHS will not impose civil money penalties in 2016 or later based on activities that occurred in the 2014 or 2015 calendar year if the issuer acted in good faith at that time.

f. Default Risk Adjustment Charge (§ 153.740(b))

In the second Program Integrity Rule and the 2015 Payment Notice, HHS indicated that a default risk adjustment charge will be assessed if an issuer does not establish a dedicated distributed data environment or submits inadequate risk adjustment data. In the 2016 Payment Notice, we established how a default risk adjustment charge will be allocated among risk adjustment covered plans.

As described in the second final Program Integrity Rule, the total risk adjustment default charge for a risk adjustment covered plan equals a PMPM amount multiplied by the plan's enrollment.

$T_n = C_n * E_n$

Where:

T_n = total default risk adjustment charge for a plan n;
C_n = the PMPM amount for plan n; and
E_n = the total enrollment (total billable member months) for plan n.

In the second final Program Integrity Rule, we provided that E_n could be calculated using an enrollment count provided by the issuer, using enrollment data from the issuer's MLR and risk corridors filings for the applicable benefit year, or other reliable data sources.

In the 2015 Payment Notice, we determined that we would calculate C_n—the PMPM amount for a plan—equal to the product of the statewide average premium (expressed as a PMPM amount) for a risk pool and the 75th percentile plan risk transfer amount expressed as a percentage of the respective Statewide average PMPM premiums for the risk pool. The nationwide percentile would reflect only plans in States where HHS is operating the risk adjustment program and would be calculated based on the absolute value of plan risk transfer amounts. The PMPM amount determined using the method described here would be multiplied by the non-compliant plan's enrollment, as determined using the sources finalized in the second final Program Integrity Rule, to establish the plan's total default risk adjustment charge.

For the second year of risk adjustment, the 2015 benefit year, we proposed to calculate C_n in the same manner, but increased to the 90th percentile plan risk transfer amount expressed as a percentage of the respective statewide average PMPM premiums for the risk pool. We believe that the 75th percentile was reasonable for the initial year of risk adjustment, as we did not yet know the distribution of risk adjustment transfers and issuers were more likely to experience technical difficulties in establishing a dedicated distributed data environment. In the second year of risk adjustment, now that issuers have set up EDGE servers and participated in the calculation of risk adjustment transfers, we believe that adjusting the default charge upwards to the 90th percentile of plan risk transfer amounts expressed as a percentage of the respective statewide average PMPM premiums for the risk pool will encourage continued compliance with risk adjustment data submission requirements. We are concerned that, absent this change, some issuers may prefer receiving a default charge at the 75th percentile over participating in the risk adjustment program; a default charge at this level might lack sufficient deterrent value. We stated that we believe the proposed 90th percentile default charge will incentivize issuers to participate in the risk adjustment program.

Comment: Commenters generally supported the increased default risk adjustment charge for 2015 benefit year risk adjustment. Two commenters opposed the increase, stating the increase is overly punitive.

Response: We believe that the increased default charge will encourage participation in the second year of implementation of the risk adjustment program. In establishing the amount of the default charge, we must balance setting a fair risk allocation and discouraging strategic behavior from issuers with low-risk enrollees against avoiding unduly penalizing issuers who fail to make proper submissions for operational, and not strategic, reasons. In the second year of risk adjustment, we believe that most issuers will encounter fewer operational difficulties in establishing an EDGE server and meeting data quantity and quality thresholds, and that the opportunity for strategic behavior is greater because risk transfer distributions will be better understood. We believe that raising the default risk adjustment charge from the 75th percentile PMPM transfer amount to the 90th percentile transfer amount is a fair balancing of these goals. We are finalizing this policy as proposed

For the 2016 benefit year, we proposed a separate calculation of C_n for issuers where E_n statewide, in the individual and small group markets combined, is 500 billable member months or fewer. For these issuers, we proposed to calculate C_n, or the PMPM charge for a plan, as 14 percent of premium, which we calculated as the mean charge as a percent of premium of issuers with 500 billable member months or fewer in the 2014 benefit year in the small group market. We based the charge itself on the experience of small group issuers in the 2014 benefit year, as we believe that individual market issuers are more likely to set up an EDGE server because of the availability of reinsurance. Limiting the applicability in the 2016 benefit year of this default charge to issuers with 500 billable member months or fewer is intended to ensure that the only issuers with this option are issuers that are so small that their removal from the overall risk adjustment risk pool would have a minimal impact on transfers nationwide. In 2014, approximately 125 issuers would have had fewer than 500 member months in the individual and small group markets combined. Of those approximately 125 small issuers, 80

were assessed risk adjustment charges greater than the proposed default charge of 14 percent of premium PMPM. Those charges amounted to less than 0.09 percent (that is, less than one tenth of one percent) of total risk adjustment charges assessed nationally. Assuming every one of those issuers elect to accept the proposed 14 percent default risk charge, and none of the small issuers that received risk adjustment payments or with charges below 14 percent of premium PMPM did so (which we believe unlikely, due to the administrative expenses of setting up an EDGE server), the assessment of the proposed 14 percent of premium default charge on those 80 issuers would have resulted in a 0.05 percent reduction in risk adjustment charges collected nationally. Because issuers of this size have a minimal impact on the overall risk adjustment risk pools and have a disproportionately high operational burden to comply with risk adjustment data submission requirements, we believe that a separate default charge for these issuers would promote efficiency and data quality in the risk adjustment program. We proposed to establish this risk adjustment default charge as the mean charge in the small group for these small issuers, or 14 percent of statewide average premium PMPM, to compensate on average for the absence of these immaterial amounts in the affected risk pools. We intend that this policy would apply only to the very smallest issuers, in recognition of the disproportionately high operational burden on these issuers.

Comment: Commenters opposed the separate, lower default charge, stating that compliance with risk adjustment is a cost of doing business under the Affordable Care Act. One commenter stated that the 500-member-months threshold is too small. One commenter recommended a graded approach to the default risk charge that would adjust the percentile factor from 50th to 75th for those issuers with 500 to 2,000 billable members to allow an issuer more flexibility as they transition into participation on the EDGE server. One commenter recommended that the threshold should be 720,000 billable member months.

Response: We agree that, in general, compliance with risk adjustment is a cost of doing business under the new market rules. However, as we explained in the proposed rule, we believe that an exception for the very smallest issuers recognizes that for those issuers the administrative costs of implementing an EDGE server will substantially outweigh the risk adjustment benefits to the risk pool. We are finalizing this policy as proposed.

g. Insolvent Issuers

We are aware that a health insurance issuer may become insolvent or exit a market during a benefit year. In some cases, another entity, such as another issuer or liquidator may take over the issuer's operations, or a State guaranty fund may become responsible for paying claims for the insolvent issuer. In some instances when this occurs, both the insolvent issuer and the entity seeking to acquire business from the insolvent issuer would lack a full year of enrollee data to submit to the EDGE server for the risk adjustment or reinsurance programs.

To address this concern, we proposed to clarify that an entity acquiring or entering into another arrangement with an issuer to serve the current enrollees under a plan, or a State guaranty fund that is responsible for paying claims on behalf of the insolvent issuer, with substantially the same coverage terms may accrue the previous months of claims experience for purposes of risk adjustment and reinsurance to fully reflect the enrollees' risk and claims costs. We proposed the ''substantially the same'' standard because we understood that in many of these situations, an acquiring entity's platform may require some adjustments to the plan arrangements and coverage terms. As part of meeting this standard, an acquiring entity would be required to carry over of accumulators for deductibles and annual limitations on cost sharing. If the substantially the same standard is met, and the insolvent issuer and acquiring entity agree that the acquiring entity will accrue the previous months of claims experience, the acquiring entity must take responsibility for submitting to HHS complete and accurate claims and baseline information for that benefit year (including data from the insolvent issuer) in accordance with HHS's operational guidance to maintain eligibility to receive payments under this program for the given benefit year. Operationally, the acquiring entity may elect to have the insolvent issuer submit the data on behalf of both entities. We will work with issuers and other acquiring entities in these situations to facilitate the submission of the necessary data to EDGE servers for HHS to calculate risk adjustment financial transfers and reinsurance payments.

We also recognized that guaranty funds may not meet all of the requirements to be considered a risk adjustment covered plan or reinsurance eligible plan (for example, they may not meet the definition of ''health insurance issuer''), and so we proposed to permit a guaranty fund to participate in those programs notwithstanding these definitions, to the extent it has taken over liability for a risk adjusted covered plan or reinsurance eligible plan during a benefit year.

We sought comment on these policies, including with respect to permissible ways in which the acquiring entity's arrangements may differ and other ways of ensuring the submission of the data necessary for HHS to calculate the risk adjustment financial transfer amounts and the reinsurance payment amounts when another party will take over operations of the insolvent issuer, or pay claims on behalf of the insolvent issuer, during a benefit year. We also solicited comments on whether additional flexibility is needed with respect to the data submission requirements for the reinsurance and risk adjustment programs, such as with respect to the definition of a ''paid claim'' to account for situations when an issuer is unable to pay claims for covered services, for example, due to insolvency.

We received a number of comments on these policies. Most commenters supported the general intent of the policies but requested additional information or clarification of certain aspects of them. We are finalizing this policy with certain clarifications, as detailed below.

Comment: Two commenters requested that we clarify the term ''substantially the same'' in this context, and one of these commenters questioned whether a guaranty fund that pays only a portion of the original covered benefits would meet this standard.

Response: With respect to the acquisition of business from an insolvent issuer, an acquiring entity must, at a minimum, carry over accumulators for deductibles and annual limitations on cost sharing to meet the substantially the same standard. We note that this standard is unrelated to the standards under § 153.500 for determining whether a health plan offered outside of the Exchange is the same as a QHP for the purposes of the risk corridors program. We will continue to monitor situations involving issuer insolvencies and intend to issue further guidance as necessary.

Comment: Two commenters expressed concern about the opportunity for gaming by acquiring issuers if they have the option, but are not required to accrue and submit claims experience for the insolvent issuer, because they could select the

approach that would be most favorable to their risk adjustment calculation.

Response: We appreciate the concern, but we believe that a single EDGE server submission better reflects the true economic risk of the enrollment in the plans of the insolvent issuer, and note that an acquiring entity taking over the insolvent issuer's business could structure the acquisition to provide for separate submissions. We will work with issuers and acquiring entities in these situations to facilitate the submission of accurate and complete data to EDGE servers that is necessary to calculate risk adjustment financial transfers and reinsurance payments.

Comment: One commenter encouraged us to address situations involving a State guaranty fund or liquidator separately from those involving an acquiring issuer, given their differing roles and responsibilities. This commenter also requested that liquidators, in addition to guaranty funds, be given explicit ability to participate in the reinsurance and risk adjustment programs as they are often responsible for providing pre-liquidation coverage. Another commenter questioned whether a guaranty fund would be able to participate in risk adjustment under State law or operationally. A separate commenter proposed that the policies apply to providers in the same manner as guaranty associations, because the majority of issuers in its State are not subject to the guaranty association to pay claims; however, providers are required to hold consumers harmless if their insurance company becomes insolvent.

Response: We clarify that this policy permits participation of a liquidator or a State guaranty fund in the risk adjustment and reinsurance programs, to the extent it has taken over liability for a risk adjustment covered plan or reinsurance eligible plan during a benefit year, unless otherwise prohibited by State law. We recognize that restrictions under State law, or operational limits, may apply. In the case where a guaranty fund assumes liability for a risk-adjustment covered plan or reinsurance eligible plan, the guaranty fund would submit data acting on behalf of the insolvent issuer; however, the insolvent issuer would retain responsibility for the coordination of the EDGE data submission. While we understand that policyholders in some States are not covered by guaranty funds, it is not clear how providers could coordinate the submission of an EDGE server because the responsibility to submit data to the EDGE server applies to the issuer and the EDGE server does not support the submission of individual claims from providers.

Comment: One commenter recommended that, in the event that an issuer in a market in a State is unable to pay a risk adjustment charge in full, HHS adjust both risk adjustment payments and charges in that market and State, rather than only payments, to ensure that the shortfall is distributed proportionally among issuers in the risk pool.

Response: We appreciate the recommendation and will consider proposing this approach in rulemaking for future benefit years.

E. Part 154—Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

1. Disclosure and Review Provisions

a. Rate Increases Subject To Review (§ 154.200)

In the proposed rule, we proposed amending paragraph (c)(2) of § 154.200 to re-establish that a rate increase for single risk pool coverage effective on or after January 1, 2017, must be calculated as the premium-weighted average rate increase for all enrollees. The proposed change would reverse a previous amendment [24] that defined a rate increase for single risk pool coverage effective on or after January 1, 2017 as an increase in the plan-adjusted index rate. We note that the previous amendment also established a plan level trigger for a product being subject to review for coverage effective on or after January 1, 2017. The proposed amendment maintained the plan level trigger for the subject-to-review threshold.

We proposed the amendment to the calculation method because an increase in the plan-adjusted index rate does not reflect changes to adjustment factors for rating area, age, or tobacco use. For example, an issuer could change geographic rating area factors such that members in a certain rating area receive a larger increase, but if the plan-adjusted index rate did not meet or exceed the threshold then the rate increase would not be subject to rate review.

We are finalizing this section as proposed, so that a rate increase for single risk pool coverage effective on or after January 1, 2017 is subject to review if the average increase, including premium rating factors described in § 147.102, for all enrollees weighted by premium volume for any plan within the product meets or exceeds the applicable threshold. This amendment strengthens consumer protections against unreasonable rate increases by ensuring that coverage with a significant rate increase due to changes in rating factors is subject to review.

We maintain that the plan level rate increase, as opposed to the product level rate increase, will determine whether the increase is subject to review. The plan level trigger was finalized in the 2016 Payment Notice (80 FR 10781) effective for coverage beginning on or after January 1, 2017.

Comment: Some commenters expressed concern regarding the inclusion of premium rating factors and requested HHS clarify how rate changes should be calculated according to the proposal.

Response: All rating factors, including rating area and tobacco use factors, should be captured in the calculation of plan rate changes. The intent here, in the context of the rate review program, is to measure the premium change based on an issuer's current population compared to that same population if the new rates were implemented. This is not intended to capture demographic changes, such as a member aging up or moving to a new geographic location.

b. Submission of Rate Filing Justification (§ 154.215)

In the proposed rule, we proposed to revise § 154.215(a)(1) to require health insurance issuers to submit the Unified Rate Review Template (also known as Part I of the Rate Filing Justification) for all single risk pool coverage in the individual or small group (or merged) market, regardless of whether any plan within a product is subject to a rate increase. This proposal was made to carry out the Secretary's responsibility, in conjunction with the States, under section 2794(b)(2)(A) of the PHS Act to monitor premium increases of health insurance coverage offered through as well as outside of an Exchange. We also expressed our intent to disclose information that is not a trade secret or confidential commercial or financial information for all proposed rate increases for single risk pool coverage, rather than only proposed rate increases subject to review, as well as all final rate increases.

We proposed to revise paragraph (a) to insert paragraph (a)(1) to establish that health insurance issuers must submit the Unified Rate Review Template (''URRT,'' also known as Part I of the Rate Filing Justification) for all single risk pool products in the individual or small group (or merged) market, regardless of whether any plan within a product is subject to a rate

[24] 80 FR 10749, 10863 (Feb. 27, 2015).

increase. We also proposed to insert paragraph (a)(2) to capture the existing requirement that issuers must submit a URRT and an Actuarial Memorandum (also known as Parts I and III of the Rate Filing Justification) when a single risk pool product has a plan that is subject to a rate increase of any size. Similarly, we proposed to insert paragraph (a)(3) to capture the existing requirement that an issuer must provide that all three parts of the Rate Filing Justification (that is, the Part I URRT, the Part II written description justifying a rate increase, and the Part III Actuarial Memorandum) when a single risk pool product has a plan with a rate increase that is subject to review. Accordingly, we proposed to revise paragraph (b) to provide that a Rate Filing Justification for single risk pool plans must include one or more of the three parts, as appropriate, but not necessarily all three. We also proposed to remove and reserve paragraph (c), as it was unnecessary in light of the proposed amendments to paragraphs (a) and (b). We are finalizing all of the amendments to this regulation as proposed.

Comment: A majority of commenters supported the proposal and several recommended that all proposed rate changes should be made public, rather than just proposed rate increases. Some commenters, however, expressed concern regarding the proposal, citing the statutory obligation to review only unreasonable premium increases, rather than all increases. A few commenters stated that publicizing rate filings before they are finalized eliminates competitive advantages for plans.

Response: We are finalizing the proposal to collect rate filings for all single risk pool products in order to carry out the Secretary's statutory responsibility [25] to monitor premium increases of health insurance coverage. HHS will post information for all proposed rate filings for the individual and small group markets within a state at a uniform time to promote fair market competition between issuers through and outside of the Exchange and further enhance transparency of the rate-setting process. We note that States with an Effective Rate Review Program are required to post proposed rate increases subject to review and have a mechanism for receiving public comments on those proposed rate increases. CMS's decision to post information for all proposed rate filings for single risk pool coverage does not affect or change the State's obligation to post proposed rate increases under § 154.301(b).

Comment: Some commenters requested that HHS should make final rate information publicly available at least 15 days before open enrollment.

Response: Final rate increase information must be posted at a uniform time for all single risk pool coverage (regardless of whether the coverage is sold on the Exchange) by the first day of open enrollment,[26] but States may establish an earlier uniform posting timeframe with appropriate notice to CMS.[27] We believe this timeframe strikes a balance between providing State and Federal regulators sufficient time to complete their reviews, while providing consumers the information needed to make informed purchasing decisions.

c. Timing of Providing the Rate Filing Justification (§ 154.220)

In the proposed rule, we proposed technical changes to § 154.220 to remove references to rate increases and clarify that the timeframes listed pertain to all single risk pool products with or without rate changes to conform with the proposed amendments to § 154.215. We are finalizing the amendments to this regulation as proposed.

Comment: Some commenters requested that HHS change the filing deadline to a time after the risk adjustment report is released to issuers. Other commenters suggested States establish their own rate filing submission deadlines rather than adhering to HHS filing deadlines.

Response: We acknowledge the comments, and consistent with the approach outlined in guidance being released with this rule,[28] we are providing States with an effective rate review program [29] with additional flexibility with respect to the submission deadline for proposed rate filings for single risk pool products. Issuers in a State effective rate review program must submit proposed rate filings for single risk pool coverage (for both QHPs and non-QHPs) on a date set by the State, so long as the date is not later than July 15, 2016. We encourage States with effective rate review programs that are served by the HealthCare.gov platform to set a date that aligns with the Federally-facilitated Exchange QHP filing deadlines; [30] however, we understand some States may face challenges in doing so. Issuers in States without effective rate review programs [31] must submit proposed rate filings for single risk pool coverage (for both QHPs and non-QHPs) on a date set by the State, so long as the date is not later than May 11, 2016. Further, we note that all States retain flexibility to establish an earlier submission date under § 154.220(b).

d. Submission and Posting of Final Justifications for Unreasonable Rate Increases (§ 154.230)

We proposed to fix a typographical error and change the cross reference in § 154.230(c)(2)(i) to reference § 154.215(h) rather than § 154.215(i). There were no comments submitted regarding this section. We are finalizing the amendment as proposed.

e. CMS's Determinations of Effective Rate Review Programs (§ 154.301)

In the proposed rule, we restated that making rate information available to the public at a uniform time (rather than a rolling basis) is one of the criteria for determining whether a State has an Effective Rate Review program.[32] We expressed our intent to propose a uniform timeline for release of proposed rate increases subject to review and for all final rate increases for single risk pool coverage. We are maintaining the requirement for releasing rate information at a uniform time rather than on a rolling basis. We released the proposed timeline for the 2016 Filing Year on December 23, 2015.[33] Public comments were accepted until January 22, 2016. We are releasing the final timeline in guidance [34] with this final rule, as discussed above.

Comment: Many commenters expressed support for requiring States to post all rate increases at the same time. Some commenters opposed having a uniform posting timeline, requesting that States be able to establish the timeline for SBEs.

[25] Section 2794(b)(2)(A) of the Public Health Service Act.

[26] § 154.301(b)(1)(ii).

[27] § 154.301(b)(2).

[28] CMS Insurance Standards Bulletin: Timing of Submission and Posting of Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Coverage, (Feb. 29, 2016).

[29] See 45 CFR 154.301 for a list of criteria that CMS considers when evaluating whether a State has an effective rate review program

[30] Final 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016).

[31] For the 2017 plan year, health insurance issuers in Alabama, Missouri, Oklahoma, Texas, and Wyoming are required to submit rate filings for review by CMS to determine reasonableness.

[32] § 154.301(b).

[33] DRAFT Bulletin: Timing of Submission and Posting of Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Coverage1 Effective on or after January 1, 2017, (Dec. 23, 2015), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Timeline-Bulletin-12-23-15-FINAL.pdf.*

[34] CMS Insurance Standards Bulletin: Timing of Submission and Posting of Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Coverage (Feb. 29, 2016).

Response: The requirement for a State with an Effective Rate Review program to post proposed rate increases that it reviews, and to have a mechanism for receiving public comments on those proposed rate increases, has been in effect for several years. The uniform timeline requires States to ensure that the proposed rate increases subject to review, as well as all final rate increases, are released to the public at the same time. This policy ensures that rate information is available simultaneously for coverage offered through and outside of the Exchange, which enhances transparency and promotes fair market competition. We note that the guidance being released with this final rule provides States with an effective rate review program with flexibility to set a date to post proposed rate filings for single risk pool products with rate increases subject to review, provided the date set by the State is no later than August 1, 2016. Nothing in this rule prevents States from making additional information available to the public, or prevents States from establishing earlier uniform timeframes for public disclosure.

F. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Definitions (§ 155.20)

In § 155.20, we proposed to amend the definition of ''applicant'' for the small group market so that the term also includes an employer seeking eligibility to purchase coverage through a SHOP, without necessarily enrolling in that coverage themselves. The current definition of an applicant contemplates an employer, employee, or former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself. For consistency with our existing regulations governing the SHOP application process at §§ 155.710 and 155.715 and for consistency with how the small group market typically works, we proposed that the term applicant also include an employer who is seeking eligibility to purchase coverage through a SHOP, but who is not seeking to enroll in that coverage for himself or herself. We received no comments on this proposal and are finalizing this amendment as proposed.

We proposed to modify the definitions of ''small employer'' and ''large employer'' at § 155.20 to align with the Protecting Affordable Coverage for Employees Act, which was recently enacted, as further described in the preamble to § 144.103. For a discussion of the provisions of this final rule related to the definitions of small employer and large employer in § 155.20, please see the preamble to § 144.103. We did not propose to change the applicability of the counting methodology under section 4980H(c)(2) of the Code to these definitions in § 155.20, but we proposed amendments to these definitions that eliminate language about the timing of the applicability of the counting methodology under section 4980H(c)(2) of the Code under these definitions, because that language is no longer relevant. We did not receive any comments regarding this aspect of the proposal and are finalizing as proposed the elimination of the language about the timing of applicability of the counting methodology under section 4980H(c)(2) of the Code.

We proposed to amend § 155.20 to add a definition for ''Federal platform agreement'' to apply to this part. We defined a Federal platform agreement to mean an agreement entered into by a State Exchange and HHS, under which the State Exchange agrees to rely on the Federal platform to carry out select Exchange functions. We are finalizing the definition, with a slight modification to reflect the fact that the State election to implement the SBE–FP would occur through the Blueprint process in § 155.106(c) rather than the Federal platform agreement, which will reflect the agreement between the parties and will be entered into at the end of the Blueprint process. The Federal platform agreement, which we will publish later this year, will also contain the parties' mutual obligations with respect to those Exchange functions and related matters.

For a discussion of the provisions of this final rule regarding standardized options, please see the preamble to part 156, regarding standardized options.

2. General Standards Related to the Establishment of an Exchange

a. Election To Operate an Exchange After 2014 (§ 155.106)

We proposed to modify the timeframes for submission and approval of documentation specifying how an Exchange established by a State or a regional Exchange meets the Exchange approval standards (that is, the Exchange Blueprint). Based on our experience over the last two open enrollment periods, we believe the current Exchange Blueprint application deadlines for States intending to operate a State Exchange do not sufficiently balance the need to provide States with time to adequately prepare their Blueprint applications against the need to ensure HHS has sufficient time to accurately assess a State's progress and ability to timely build the necessary Exchange information technology. In our experience, the process for seeking approval to operate a State Exchange involves substantial technical assistance and collaboration between HHS and the State in developing plans to transition from one Exchange operational model and information technology infrastructure to another, including key milestones, deadlines, and contingency measures. Since the completion of some of these key milestones and deadlines would need to occur prior to the submission of the Blueprint application, we proposed that we will make that technical assistance available and initiate the transition process following submission of a declaration letter from the State, as provided for in the Blueprint approval process. The declaration letter would serve as formal notification to HHS of a State's intent to operate a State Exchange, including operating an SBE–FP, and to submit a Blueprint (or Blueprint update) for HHS approval. The declaration letter would initiate coordination between the State and HHS on a transition plan. The declaration letter would also serve as a starting point for HHS to communicate the operational steps that a State must complete in order to become an SBE, as well as a starting point for HHS to assess a State's progress by the time of the State's Blueprint or Blueprint update submission. We would require a declaration letter approximately 21 months prior to the beginning of the SBE's first annual enrollment and approximately 9 months prior to the beginning of an SBE–FP's first annual open enrollment. HHS would assess later submissions on a case-by-case basis, recognizing operational realities and need for adequate notice for stakeholders, including issuers and consumers.

In § 155.106(a)(2), we proposed to require States that are establishing a State Exchange (not including a State Exchange using the Federal platform for certain functions) to submit an Exchange Blueprint at least 15 months prior to the date the Exchange proposes to begin open enrollment as a State Exchange. We also proposed in § 155.106(a)(3) to increase the time that the State must have in effect an approved or conditionally approved Exchange Blueprint from 6.5 months to 14 months prior to the date the Exchange proposes to begin open enrollment as a State Exchange. We recognized that in some situations the open enrollment period may not have

been established when Blueprints are due. Therefore, we proposed in paragraph (a)(5), if the open enrollment period for the year the State intends to begin operating an SBE has not been established, a State should assume open enrollment will begin on the same date as open enrollment is to begin for the year in which they are submitting the Blueprint.

We proposed to revise paragraph (b) to clarify that HHS will operate the Exchange if a State Exchange ceases operations.

We proposed to add a paragraph (c) to establish requirements for a State that elects to operate an SBE–FP. These States must submit an Exchange Blueprint (or submit an update to an existing approved Exchange Blueprint) at least 3 months prior to the date open enrollment is to begin for the State as an SBE–FP; and must have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 2 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP. If the State Exchange has a conditionally approved Exchange Blueprint application, we proposed that it would not be required to submit a new Blueprint application, but instead must submit any significant changes to that application for HHS approval at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP. As part of HHS's approval or conditional approval of the Exchange Blueprint or amended Blueprint, these States must execute a Federal platform agreement and be required to coordinate with HHS on a transition plan.

Lastly, we want to be clear that we only proposed changes to the timelines for submission of the Blueprint application. We did not otherwise propose any modifications to the information and documents that States must submit as part of the Exchange Blueprint application.

We are finalizing our proposals as proposed, except that, in order to provide additional time for the transition, we are amending the timing of the Federal platform agreement, so that it must be executed prior to approval or conditional approval of the Exchange Blueprint.

Comment: Several commenters expressed concern that the proposed Blueprint submission and approval timelines for a State transitioning to an SBE–FP do not allow sufficient time for a State and its issuers to make the necessary operational changes to prepare for the State's transition to the SBE–FP model, and for HHS to make an assessment of the State's progress. A commenter indicated that they would also like to see a timeline for when the Federal platform agreement must be fully executed. Finally, comments were received regarding the need for HHS to publish the operational steps involved in the transition to an SBE–FP, including the need for issuer outreach and flexibility in transition plans for individual States.

Response: We are finalizing the regulations as proposed. We believe that the Blueprint timeline provides sufficient time for a State to become or transition to an SBE–FP because that transition will begin with the submission of the declaration letter. Part of the technical assistance provided upon submission of the declaration letter will be the communication of the operational steps that a State must complete in order to become an SBE–FP, including the operational steps States are required to take with their issuers. We plan to publish guidance on these operational steps.

b. Additional Required Benefits (§ 155.170)

Section 1311(d)(3)(B) of the Affordable Care Act permits a State, at its option, to require QHPs to cover benefits in addition to the EHB, but requires a State to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional State-required benefits. In the 2016 Payment Notice, we instructed States to select a new EHB base-benchmark plan to take effect beginning for the 2017 plan year. The final EHB base-benchmark plans selected as a result of this process have been made publicly available.[35]

Section 1311(d)(3)(B) of the Affordable Care Act refers to situations in which the State requires QHPs to cover benefits. That section is not specific to State statutes, and we have interpreted that section to apply not only in cases of legislative action but also in cases of State regulation, guidance, or other State action. Therefore, we proposed to reword § 155.170(a)(2) to make clear that a benefit required by the State through action taking place on or before December 31, 2011 is considered an EHB.

In the EHB Rule (78 FR 12837 through 12838), we discussed § 155.170(a)(2), which implements section 1311(d)(3)(B) of the Affordable Care Act. In our discussion of that provision, we provided that State-required benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the State to defray costs for these State-required benefits. This policy continues to apply. Therefore, benefits required by a State through action taking place after December 31, 2011 that directly apply to the QHPs are not considered EHB (unless enactment is directly attributable to State compliance with Federal requirements, as discussed below).

Although benefits requirements enacted by States after December 31, 2011 that directly apply to the QHP and that were not enacted for purposes of compliance with Federal requirements are not considered EHB,[36] the base-benchmark plan might cover some of those non-EHB. Nonetheless, issuers must treat those benefits as they would other non-EHB, such as those identified in § 156.115(d),[37] and the State must defray the cost. We proposed to codify this interpretation in § 155.170(a)(2).

At § 155.170(a)(3), we currently require the Exchange to identify which additional State-required benefits, if any, are in excess of EHB. We proposed to amend paragraph (a)(3) to designate the State, rather than the Exchange, as the entity that identifies which State-required benefits are not EHB. We proposed this change because we believe insurance regulators are generally more familiar with State-required benefits. We believe each State should determine the appropriate State entity best suited to identify newly required benefits. Additionally, for consistency of terminology, we proposed to amend paragraph (a)(3) to replace the reference to ''in excess of EHB'' with ''in addition to EHB.''

In current § 155.170(c)(2)(iii), we require QHP issuers to quantify the cost attributable to each additional State-required benefit and report their calculations to the Exchange. We proposed to designate the State as the entity that receives issuer calculations in paragraph (c)(2)(iii). Since the Affordable Care Act requires the State to remit a payment to an enrollee or issuer, we stated that we believe the calculation should be sent directly to the State rather than to the Exchange.

[35] Available at *https://downloads.cms.gov/cciio/FinalListofBMPs_15_10_21.pdf.*

[36] The 2016 Payment Notice provides that States are not expected to defray the cost of State-required benefits enacted on or after January 1, 2012 that were required in order to comply with new Federal requirements. (80 FR 10749, 10813 (Feb. 27, 2015)).

[37] An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

The 2016 Payment Notice specified that a State may need to supplement habilitative services if the base-benchmark plan does not cover such services. We noted that if a State supplements the base-benchmark plan, there is no requirement to defray the cost of the benefits added through supplementation, as long as the State must supplement the base-benchmark to comply with the Affordable Care Act or another Federal requirement. Examples of such Federal requirements include: Requirements to provide benefits and services in each of the 10 categories of EHB; requirements to cover preventive services; requirements to comply with the Mental Health Parity and Addiction Equity Act; and the removal of discriminatory age limits from existing benefits.

In some States, the base-benchmark plan may be a large group (non-Medicaid HMO or State employee) plan. We stated that we have received questions regarding State-required benefits that are embedded in those large group base-benchmark plans. As stated earlier in this section, if the State-required benefit in question was required by State action after December 31, 2011, applies directly to the QHP, and was not enacted for purposes of compliance with Federal requirements, the benefit is not considered EHB, even if the benefit is embedded in the base-benchmark plan. However, we stated that a benefit required only in the large group market and reflected in a large group base-benchmark plan is not an EHB for QHPs offered in the individual or small group markets because such a benefit requirement does not apply directly to those plans, and to the extent it is included in the base-benchmark plan, it may be substituted for, in accordance with § 156.115(b). Therefore, the State would not have to defray the cost of individual and small group market QHPs covering State-required benefits that are required in the large group market only. (However, to the extent the State permits large group plans to be sold as QHPs through the State's Exchange, the State would have to defray the cost of the large group QHPs covering the mandated benefit.) We noted that plans subject to the EHB requirements offered in the individual and small group markets in those States would have to be substantially equal to the base-benchmark plan, and therefore may cover the State-required benefit as EHB since it is embedded in the base-benchmark plan. In such a case, we proposed to clarify that the benefit is an EHB because it is covered by the base-benchmark plan, but the cost of coverage by individual and small group QHPs does not have to be defrayed, because the State-required benefit does not apply directly to those QHPs.

We noted that some States have imposed new benefit requirements only on individual and small group plans that are not QHPs such that only individual and small group plans sold outside the Exchange must cover the State-required benefit. We noted that a QHP generally may be sold outside the Exchanges in which case it would be subject to these new benefit requirements. We cautioned States, however, that imposing different benefit mandates depending on a plan's status as a QHP or because it is sold through the Exchange may violate section 1252 of the Affordable Care Act. Under this section, State standards or requirements implementing, or related to, standards or requirements in title I of the Act must be applied uniformly within a given insurance market. Thus, if a State requires that non-QHPs in the individual or small group market provide any benefits, under section 1252, the State must require QHPs sold through the Exchange in that same market to provide those same benefits, and consistent with our earlier stated policy at § 155.170(a)(2), States would generally be required to defray the cost of QHPs providing the required benefits if they were required through State action taking place after December 31, 2011.

We noted that the Protecting Affordable Coverage for Employees Act, enacted in October 2015, amended the definitions of small employer and large employer in section 1304(b) of the Affordable Care Act and section 2791(e) of the PHS Act such that a small employer is generally [38] an employer with 1–50 employees, with the option for States to expand the definition of small employer to 1–100 employees.[39]

We noted that several States have enacted benefit requirements that would apply to small group insurance plans offered to employers with 51–100 employees, but not to employers with 1–50 employees. This may arise because the State-required benefit was designed to apply only in the large group market when the large group market included employers with more than 50 employees, but the State has since then availed itself of the option to define a small employer as an employer with 1–100 employees.

We noted that section 2702 of the PHS Act and § 147.104 generally require an issuer to offer all approved products to any individual or employer in the market for which the product was approved and to accept any individual or employer that applies for any approved product in a given market. If a State elects to expand the definition of small employer so that it covers employers with 1–100 employees, all products approved for sale in the small group market (defined by the State as 1–100 employees) generally must be offered to employers with 1–100 employees. This effectively means that existing State benefits mandates that apply to insurance coverage sold to employers with 51–100 employees would then effectively also apply to all products sold to employers with 1–100 employees. As long as the benefit was required by State action taken on or before December 31, 2011, the expansion of coverage would not trigger the requirement to defray, because the expansion was required to comply with Federal guaranteed availability laws. If a State does not opt to expand the definition of small employer to 1–100 employees, then any State-required benefits applicable in the large group market (including to employers with 51–100 employees) would continue to not apply in the small group market. If a State-required benefit was imposed by State action taking place January 1, 2012 or later, then defrayal generally would be required. We are finalizing our proposals and clarifications as proposed.

Comment: Several commenters agreed that a benefit required by a State through action taking place on or before December 31, 2011 is considered an EHB. Multiple commenters supported the proposal that States and not the Exchange identify what is in addition to EHB.

Response: We agree that a benefit required by action taking place on or before December 31, 2011 is considered EHB; this has been our policy since releasing the EHB Rule. We recognize that States regulators are generally more familiar with State-required benefits than an Exchange. We believe each State should determine the appropriate State entity best suited to identify newly

[38] Prior to enactment of the Protecting Affordable Coverage for Employees Act, small employer was defined to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In case of plan years beginning before January 1, 2016, a State was able to elect to define small employer by substituting ''50 employees'' for ''100 employees''. For ease of reference with regard to this section, we will refer to employers as having 1–50 or 1–100 employees.

[39] States that elect to extend the small employer definition were requested to notify CMS of their election by October 30, 2015 at *marketreform@cms.hhs.gov.*

required benefits. Therefore, we are finalizing the rule as proposed.

Comment: Numerous commenters questioned how States can supplement an EHB category without assuming the financial burden. Multiple commenters sought guidance on how to determine that a State requirement, particularly a habilitative services requirement, goes beyond EHB, and how to determine the additional cost attributed to each such additional required benefit.

Response: The ten categories of EHB, and the process for supplementing base-benchmark plans to establish EHB-benchmark plans, are outlined in § 156.110. In the 2016 Payment Notice (80 FR 10749, 10813), we stated that benefit requirements enacted by States after December 31, 2011 that directly apply to QHPs, and that were not enacted for purposes of compliance with Federal requirements are not considered EHB. We also stated that if the base-benchmark plan does not include coverage for habilitative services, the State may define that benefit category. There is no requirement to defray the cost of the State-required benefits, as long as the State requirement is consistent with section 1302 of the Affordable Care Act and § 156.110. We also note that § 156.110(f) allows States to determine services included in the habilitative services and devices category if the base-benchmark plan does not include coverage; and that States are not expected to defray the cost of State-required benefits enacted after December 31, 2011 that were required in order to comply with new Federal requirements. We are affirming that the State has the flexibility to define habilitative services; however, the State must use a reasonable interpretation as to what services are habilitative. Further, a State may also modify that definition in future years, as medical evidence and treatments evolve. We note that any State definition must comply with applicable nondiscrimination rules. This final rule requires the State to determine, based on these standards, when State requirements require issuers to provide benefits in addition to EHB.

Section 155.170(c)(1) requires issuers to quantify the cost attributable to each additional State-required benefit. We are finalizing our proposal that QHP issuers must report their calculation to the State. Since the State is required by statute to remit a payment to an enrollee or issuer, we believe the calculation should be sent directly to the State rather than to the Exchange. The actual cost attributed can then be made public by the State, if it so chooses. Section 155.170(c)(2)(i) through (iii) states that QHP issuers' calculations must (1) be based on an analysis performed in accordance with generally accepted actuarial principles and methodologies; (2) conducted by a member of the American Academy of Actuaries; and (3) reported to the State.

Comment: Some commenters disagreed with our interpretation that State-required benefits that apply only to individual and small group plans that are not QHPs may violate section 1252 of the Affordable Care Act.

Response: Section 1252 of the Affordable Care Act provides that State requirements under Title I of the Affordable Care Act must be applied uniformly to all health plans in an insurance market. We reiterate that a requirement that depends upon a plan's status as a QHP or whether it is sold through the Exchange may violate section 1252 of the Affordable Care Act.

Comment: Some commenters expressed concerns about discriminatory benefit design, and sought further guidance regarding what benefit designs could be deemed discriminatory.

Response: Under § 156.125(a), an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Furthermore, plans may not establish annual dollar limits on individual items or services that are EHB. We will consider providing further guidance regarding discriminatory benefit design in the future.

3. General Functions of an Exchange

a. Functions of an Exchange (§ 155.200)

We proposed a technical correction to § 155.200(a) to include a reference to subpart M, which establishes oversight and program integrity standards for State Exchanges, and subpart O, which establishes quality reporting standards for Exchanges.

We also proposed to amend § 155.200 by adding a paragraph (f) to address SBE–FPs. This arrangement is intended to permit a State Exchange to leverage existing Federal assets and operations by relying on HHS services for performing certain Exchange functions, particularly eligibility and enrollment functions. The SBE–FP would also rely on HHS to perform certain consumer call center functions and casework processes, and maintain related information technology infrastructure. The SBE–FP would retain responsibility for plan management functions, including QHP certification functions, subject to certain rules requiring the SBE–FP to require its QHP issuers to comply with certain FFE standards governing QHPs and issuers (as proposed in § 155.200(f)(2) of this proposed rule), and consumer support functions, subject to FFE rules governing consumer assistance functions.

Under § 155.200(f)(1), we proposed that a State may receive approval or conditional approval to operate an SBE–FP through the Blueprint process under proposed § 155.106(c) and meet its obligations under § 155.200(a) by entering into a Federal platform agreement with HHS. Through the Federal platform agreement, an SBE–FP would agree to rely on HHS for services related to the individual market Exchange, the SHOP Exchange, or both the individual market and SHOP Exchanges. The Federal platform agreement would specify the Federal services on which the State Exchange relies, the user fee (as specified at § 156.50(c)(2)) that HHS will collect from issuers in that SBE–FP for the Federal services, and other mutual obligations relating to the arrangement, including obligations for the transfer of data. The Federal platform agreement would specify expectations between the State and HHS across various operational areas. We indicated our intent to release the Federal platform agreement at a later date. We noted that at this point the Federal services on which SBE–FPs may rely will come as an entire package. That is, HHS will not at this time offer a ''menu'' of Federal services from which an SBE–FP may select some but not other services available on the Federal platform. However, we indicated we would explore the feasibility of doing so in the future.

Although the SBE–FPs would retain primary responsibility for certifying QHPs and overseeing QHPs and issuers, we proposed under § 155.200(f)(2) to require an SBE–FP to establish and oversee certain requirements for its QHPs and QHP issuers that are no less strict than the requirements that apply to QHPs and QHP issuers on an FFE. We proposed these requirements to include the existing and proposed standards under the following sections: § 156.122(d)(2) (the requirement for QHPs to make available published up-to-date, accurate, and complete formulary drug list on its Web site in a format and at times determined by HHS); § 156.230 (network adequacy standards); § 156.235 (essential community providers standards);

§ 156.298 (meaningful difference standards); § 156.330 (changes of ownership of issuers requirement); § 156.340(a)(4) (QHP issuer compliance and compliance of delegated and downstream entities requirements); § 156.705 (maintenance of records standard); § 156.715 (compliance reviews standard); and § 156.1010 (casework standards).

Applying the changes of ownership issuers' requirement to SBE–FPs will help fulfill the Federal platform's need for data and technical consistency. It will ensure that HHS maintains the most accurate and updated information to present a consistent experience to consumers through its branded platform, HealthCare.gov. HHS must be able to monitor and provide regulatory oversight over change in control situations with regards to the operation of the Federal platform. Change in control has a significant operational impact on the Federal platform and requires the expenditure of considerable technical resources to effectuate the change throughout the multiple systems that constitute the Federal platform.

Applying the formulary drug list, network adequacy, meaningful difference, and essential community providers standards will ensure that all QHPs on HealthCare.gov meet a consistent minimum standard and that consumers obtaining coverage as a result of applying through HealthCare.gov are guaranteed plans that meet these minimum standards. HHS has designed and implemented policy and operations for the FFE such that shoppers at HealthCare.gov can experience a consistent standard of service. We proposed that SBE–FPs that wish to rely on the HealthCare.gov platform require their issuers to meet certain minimum standards as well, since their consumers are obtaining the coverage through HealthCare.gov. SBE–FPs have the flexibility to exceed these minimum standards to the extent they do not present display problems on HealthCare.gov. Although we clearly recognize that the SBE–FPs are SBEs, and thus legally distinct from FFEs, this difference will not always be apparent to HealthCare.gov consumers. Not having these standards apply may lead to consumer confusion and dilution of consumer goodwill with respect to the plans available on HealthCare.gov. The States would still be responsible for conducting QHP certification reviews for these standards.

Applying the QHP issuer compliance and compliance of delegated or downstream entities requirement at § 156.340(a)(4), which involves the maintenance of records standards of § 156.705 and the compliance reviews for QHP issuers standards of § 156.715, will ensure that the SBE–FP has authority at least as strong as that possessed by HHS to enforce compliance with these standards and will ensure that the SBE–FP and HHS are able to access all records upon request from the issuers in the SBE–FPs.

Applying the casework standards at § 156.1010 will ensure that the SBE–FP and HHS can respond to problems about which they both bear responsibility. Since SBE–FPs must use the Federally operated Health Insurance Casework System (HICS) for handling consumer casework and meeting casework resolution timeframes as part of utilizing the Federal platform for eligibility and enrollment functions, the SBE–FP would not be overseeing casework processes. However, as with all other Exchange types, State departments of insurance will still handle appropriate consumer complaints related to issuers in their States. For cases that are Exchange-related, or those in which the consumer has chosen to contact the Exchange even after contacting the appropriate department of insurance, HHS would oversee the routing and resolution of casework. HHS's intent is to work collaboratively with the SBE–FP, similar to how HHS works with SPMs.

Finally, we proposed under § 155.200(f)(3) that HHS will work with SBE–FPs to enforce the FFE standards listed under § 155.200(f)(2) directly against SBE–FP issuers or plans who do not meet these standards. In that circumstance, we proposed that HHS would have the authority to suppress a plan under § 156.815. This will ensure that consumers shopping for coverage on HealthCare.gov have access to plans that are in compliance with the FFE standards with which SBE–FP issuers must comply as a condition of offering QHPs through a State Exchange on the Federal platform.

We intend to work closely and collaboratively with SBE–FPs, and believe that our collaboration with States that currently use the Federal platform with respect to enforcement matters has been close and effective. We are finalizing our proposals as proposed.

Comment: One commenter indicated that the inability of the Federal platform to accommodate State customization for SBE–FPs is a major disincentive for SBEs to use the Federal platform. The commenter also expressed concerns about the proposed Federal platform agreement not being able to be customized by individual State, as State procurement and contracting officials may require State specific language in contracts.

Response: We are finalizing the regulations as proposed. We intend to describe the availability of new capabilities of the Federal platform that would allow for SBE–FPs to select certain Federal services to use or to customize particular functionality in future rules, through our annual rulemaking process, as well as in future versions of the Federal platform agreement. At this time we do not foresee State-specific customization of the language in the Federal platform agreement, but will engage with States as part of the process of finalizing the agreement.

Comment: We received a comment that the proposed requirement to use the Federally operated HICS system creates procedural burdens on State-based consumer advocacy staff. The commenter recommended that consumer complaints for SBE–FPs should be referred directly to the appropriate State authority for resolution.

Response: We are finalizing the regulations as proposed. The Federally operated HICS system is closely tied to the SBE–FP's utilization of the Federal platform for eligibility and enrollment functions. While SBE–FPs must rely on the Federally operated HICS system for processing casework, we are open to future possibility of HHS coordination with SBE–FP States on consumer communications pertaining to casework and complaints to the extent it is operationally feasible. Should such coordination be operationally feasible, the roles and responsibilities between HHS and the State would be specified through the Federal platform agreement.

Comment: Regarding our proposals to apply certain FFE QHP standards to SBE–FP issuers, along with our proposed requirements pertaining to the enforcement of those standards, we received some comments that were supportive and comments that were opposed. The commenters that opposed the proposed requirements stated that SBE–FP States should maintain sole authority for setting standards for, and certifying, QHPs. One commenter stated that using two sets of enforcement standards would lead to consumer harm and insurer confusion. Another commenter expressed concern that the application of FFE standards could result in inconsistent treatment of off-Exchange QHPs and recommended that SBE–FP QHPs should be governed by the same State rules as SBEs to ensure market parity. Another commenter stated that the proposed requirements may cause confusion regarding the legal

status of SBE–FPs and the true extent to which certain Federal Exchange requirements and limitations apply. One commenter recommended that we explicitly state in the final rule that the implementing guidance issued through the annual Letter to Issuers also applies to issuers on SBE–FPs.

Response: We are finalizing the rules as proposed. HHS will coordinate with the SBE–FP on enforcement of FFE standards listed under § 155.200(f)(2) through plan suppression. SBE–FP States are being required to incorporate certain FFE QHP standards into their State's QHP standards and QHP certification process; thus, there would be only one set of QHP standards that apply to all issuers in a particular SBE–FP State. An SBE–FP would have the flexibility to exceed those FFE QHP standards when setting their QHP standards and QHP certification process should they elect to. There may be differences in standards set by an SBE–FP State for QHPs that participate in the Exchange versus plans that are offered outside of the Exchange, which can also occur in SBE and FFE States. Moving forward, the annual Letter to Issuers will include implementing guidance that is specific to SBE–FPs.

b. Consumer Assistance Tools and Programs of an Exchange (§ 155.205)

We proposed two amendments to § 155.205 to address functions of an SBE–FP. First, because an SBE–FP relies on HHS to carry out eligibility and enrollment functions, which would include relying on the FFE call center to carry out these functions, we proposed to amend § 155.205(a) to exempt an SBE–FP from the requirement to operate a toll-free call center, and instead provide that an SBE–FP must at a minimum operate a toll-free telephone hotline to respond to requests for assistance to consumers in their State, in accordance with section 1311(d)(4)(B) of the Affordable Care Act.

Secondly, we proposed to amend § 155.205(b) by adding paragraph (b)(7) to provide that an SBE–FP must, at a minimum, operate an informational Internet Web site in accordance with section 1311(d)(4)(C) of the Affordable Care Act. The informational Web site would direct consumers to HealthCare.gov to apply for, and enroll in, coverage through the Exchange.

We are also finalizing an amendment to § 155.205(b)(1), related to standardized options. For a discussion of this amendment, please see the preamble discussion of standardized options.

Comment: Some comments stated that having SBE–FPs maintain these consumer assistance features is duplicative and would cause confusion among consumers. Commenters also recommended further clarification between a toll-free call center and a toll-free telephone hotline, and defining minimum functional requirements of a toll-free hotline. Commenters also asked that HHS clarify the minimum requirements for the SBE–FPs informational Web site.

Response: We are finalizing the proposed requirement for the SBE–FP to operate a toll-free hotline and informational Web site, as this is based on statutory minimum functional requirements that an SBE (including an SBE–FP) must meet. A toll-free call center includes capabilities for processing eligibility and enrollment actions and accessing consumer information to process these actions, whereas a toll-free hotline includes the capability to provide information to consumers and appropriately direct consumers to the Federally operated call center or HealthCare.gov to apply for, and enroll in, coverage through the Exchange. Both the toll-free hotline and the informational Web site that an SBE–FP is required to operate must include the capability to direct consumers to the Federal platform services, including the FFE call center and HealthCare.gov Web site, to apply for, and enroll in, Exchange coverage. We are finalizing the requirement for SBE–FPs to operate a toll-free hotline and informational Web site.

c. Standards Applicable to Navigators Under §§ 155.210 and 155.215; Standards Applicable to Consumer Assistance Tools and Programs of an Exchange Under § 155.205(d) and (e); and Standards Applicable to Non-Navigator Assistance Personnel in an FFE and to Non-Navigator Assistance Personnel Funded Through an Exchange Establishment Grant (§§ 155.205, 155.210 and 155.215)

To help consumers apply for and enroll in QHPs and insurance affordability programs through the Exchange, we established consumer assistance programs, including the Navigator program described at section 1311(d)(4)(K) and 1311(i) of the Affordable Care Act and § 155.210. Among other duties, Navigators are required to conduct public education activities to raise awareness of the availability of QHPs; to distribute fair and impartial information concerning enrollment in QHPs and the availability of Exchange financial assistance; to facilitate enrollment in QHPs; and to provide referrals for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage. We have also established under § 155.205(d) and (e) that each Exchange must provide consumer assistance, outreach, and education functions, which must include a Navigator program and can include a non-Navigator assistance personnel program.

We proposed to amend § 155.210(e) by adding a new paragraph (e)(8) to require Navigators in all Exchanges to provide targeted assistance to serve underserved or vulnerable populations within the Exchange service area. Navigators already must have expertise in the needs of underserved and vulnerable populations, and we believe that also requiring Navigators to provide targeted assistance to these populations is critical to improving access to health care for communities that often experience a disproportionate burden of disease. We also believe that Navigators should focus their outreach and enrollment assistance efforts on harder-to-reach populations and the remaining uninsured.

Because the characteristics of underserved and vulnerable populations may vary over time and from region to region, we proposed to permit each Exchange to define and identify the underserved and vulnerable populations in its service area, and to update these definitions as appropriate. This could include an Exchange allowing its Navigator grantees to propose which communities to target, for the Exchange's approval (for example, in their grant applications). In FFEs, we proposed to identify populations as vulnerable or underserved through our Navigator funding opportunity announcements and to give FFE Navigator grant applicants an opportunity to propose additional communities to target during the grant application process. We proposed that the primary criteria used to identify such populations within the FFEs would be that the population is disproportionately without access to coverage or care, or at a greater risk for poor health outcomes. Members of these populations could be identified by age groups, demographics, disease, geography, or other characteristics as defined or approved by the Exchange. In FFEs, our proposal would apply beginning with the application process for Navigator grants awarded in 2018.

Although we did not propose to extend this requirement to certified application counselors and non-Navigator assistance personnel subject to § 155.215, we stated in the preamble to the proposed rule that we would

encourage certified application counselors and non-Navigator assistance personnel subject to § 155.215 to prioritize assisting the vulnerable and underserved populations identified by the Exchange in their communities, and we recognize that many of these assisters already focus their efforts on such populations.

Navigators would not be serving these target populations exclusively, since all Navigators are required to assist any consumer seeking assistance. As we have explained previously, all Navigators should have the ability to help any individual who seeks assistance, even if that consumer is not a member of the community or group the Navigator intends to target (*see* 78 FR 20589; 78 FR 42830; 79 FR 30270; 79 FR 30278).

We are finalizing this provision as proposed.

Comment: We received many comments supporting our proposal to require Navigators in all Exchanges to provide targeted assistance to serve underserved or vulnerable populations within the Exchange service area. Commenters agreed that reaching these populations is important to increasing awareness among remaining uninsured consumers regarding coverage options available through the Exchange, helping consumers find affordable coverage that meets their needs, and narrowing health disparities. In addition, commenters stated that Navigators are uniquely positioned to serve these populations because of established ties and pre-existing relationships. Commenters also agreed that this provision should not be extended to certified application counselors and non-Navigator assistance personnel subject to § 155.215, but said that it would be helpful for HHS to educate these assister types about this kind of targeted assistance and how they can support Navigators' efforts.

Response: We agree that requiring Navigators to target assistance to underserved and vulnerable populations is critical to improving access to health coverage. We are not extending this requirement to certified application counselors and non-Navigator assistance personnel subject to § 155.215 in this final rule, but continue to encourage these assister types to prioritize reaching and assisting the vulnerable and underserved populations identified by the Exchange in their communities, and we recognize that many of these assister types already focus efforts on such populations. HHS has previously and will continue to provide technical assistance and resources on reaching and serving a variety of vulnerable and underserved populations to all Navigators, non-Navigator assistance personnel, and certified application counselors in the FFEs.

Comment: We received several comments regarding how Exchanges should identify vulnerable or underserved populations. Many commenters suggested data sources to consult when identifying these populations. Several commenters requested that HHS provide a list of underserved or vulnerable populations, made up of populations where there was either a documented lower rate of insurance prior to the implementation of the Affordable Care Act or where current enrollment rates are lower than those of other populations. Commenters recommended specific populations for identification, including low-income individuals and families; people of color; women; people living with HIV/AIDS; people living with disabilities; rural communities; lesbian, gay, bisexual, and transgender people; people with limited English proficiency; people with transportation limitations; people with mental health needs; children and youth with special health care needs; cancer survivors; low income immigrants; patients with rare diseases; survivors of domestic violence; abandoned spouses; and pregnant women enrolled in coverage that is not minimum essential coverage. In addition, several commenters requested that HHS ensure that SBEs consult with local stakeholders when defining underserved and vulnerable populations.

Response: Because the characteristics of underserved and vulnerable populations may vary over time and from region to region, we believe that SBEs are best positioned to identify the underserved and vulnerable populations in their States who most need targeted assistance and support. Therefore, we do not intend to provide a list or otherwise identify these populations in SBEs, including SBE–FPs. We encourage SBEs to work with local stakeholders and Navigators to identify populations to target, using reliable sources of data. For FFEs, HHS will identify vulnerable or underserved populations through our Navigator funding opportunity announcements and will give FFE Navigator grant applicants an opportunity to propose additional communities to target during the grant application process, beginning with the application process for Navigator grants awarded in 2018. The primary criteria the FFEs will use to identify vulnerable or underserved populations will be if they are disproportionately without access to coverage or care, or are at a greater risk for poor health outcomes.

Comment: We received several comments requesting that HHS further explain how Navigators are expected to target or focus their work on these populations, while still fulfilling the requirement to assist any consumer seeking assistance. Commenters expressed concern that this requirement might compel Navigator organizations to limit their services to certain populations or create such a perception.

Response: This provision does not require Navigators to limit their services to the specific populations they are targeting, and we rely on Navigators' creativity and local knowledge to structure their programs so that they target one or more vulnerable and underserved populations while remaining open to all consumers. For example, a Navigator grantee might open an application and enrollment assistance location in an area populated by a community that has historically experienced heath care access barriers, and reach out to community members in ways that are culturally competent and linguistically appropriate to that community, while remaining ready to serve any consumer seeking assistance. In the FFEs, we will provide more information regarding Navigator duties, scope of activities, and program requirements in the Navigator funding opportunity announcement. SBEs, including SBE–FPs, have flexibility to provide further guidance in this area as well. Finally, we continue to remind Navigators that we interpret Navigators' duty to provide fair and impartial information and services under § 155.210(e)(2) to require that all Navigators should have the ability to help any individual who seeks assistance from the Navigator, even if that consumer is not a member of the community or group the Navigator intends to target.

Comment: We received several comments regarding the selection process for Navigator grantees. Some commenters requested that HHS encourage Exchanges to prioritize entity types (such as safety net providers) or applicants capable of reaching underserved or vulnerable populations, and some recommended specific populations of Navigator grant applicants that should be given preference. In addition, commenters requested that HHS ensure that Exchanges adjust their grant-making criteria to account for the greater time and resources necessary to reach underserved and vulnerable communities. A few commenters requested that Navigators be required or

encouraged to collaborate with providers and other organizations, such as patient-focused and community-based organizations that are also engaged in consumer health and patient education, in order to ensure that underserved and vulnerable populations are receiving assistance. A few commenters also requested that HHS develop guidance for FFE Navigators, FFE non-Navigator assistance personnel, and FFE certified application counselors on collaborating and forming partnerships with groups that are engaged in reaching populations, consumer health, and patient education.

Response: For FFEs, we will take these comments into consideration when drafting Navigator selection criteria for the Navigator funding opportunity announcements for 2018 and future years. We agree that local collaboration and leveraging community partnerships might help Navigators reach marginalized communities, and we intend to issue guidance for FFE Navigators with additional information on collaborating or partnering with other community organizations. SBEs, including SBE–FPs, are responsible for administering their own Navigator programs, including determining their own selection process, consistent with statutory and regulatory authority.

Comment: We received several comments regarding the timeframes in which these populations would be identified. Commenters requested that Exchanges regularly re-identify these populations. Some commenters requested that these populations be identified at least 3 months prior to the beginning of open enrollment and that applicants be allowed to identify new populations for each grant cycle.

Response: SBEs, including SBE–FPs, retain flexibility to administer their own Navigator programs, and we encourage SBEs to regularly revisit the ways they define and identify vulnerable and underserved populations to ensure that the results remain current and relevant. In FFEs, we will continue to prioritize publicizing and awarding Navigator grants in a transparent and timely fashion. We intend to identify these populations when each funding opportunity announcement is published, at least 60 days prior to the date applications are due.

Comment: Several commenters requested that HHS and States ensure that Navigators receive adequate resources, including funding and training, to work with vulnerable and underserved populations. Commenters urged HHS to tailor training opportunities to population-specific messages and content. Several commenters were concerned about how these activities would be funded.

Response: Under § 155.210(b)(2)(i), Navigators in all Exchanges must be trained in the needs of underserved and vulnerable populations. Under § 155.215(b)(2)(xii), Navigators in FFEs must additionally receive training on working effectively with individuals with limited English proficiency; people with a full range of disabilities; and vulnerable, rural, and underserved populations. SBEs, including SBE–FPs, are responsible for administering their own Navigator programs, including funding and budgets, and may provide or require additional training and technical assistance to address the needs of the populations they have identified as vulnerable and underserved. In FFEs, Navigator applicants will have an opportunity to propose budgets in their Navigator applications to cover the costs of these activities.

In § 155.210, we proposed to add paragraph (e)(9) to specify that Navigators in all Exchanges would be required to help consumers with certain other types of assistance, including post-enrollment assistance. We designed this proposal to ensure that consumers would have access to skilled assistance beyond applying for and enrolling in health coverage, including, for example, assistance with the process of filing Exchange eligibility appeals or with applying through the Exchange for exemptions from the individual shared responsibility payment, providing basic information about reconciliation of premium tax credits, and understanding basic concepts related to using health coverage. We discussed the statutory authority for these proposals in the preamble to the proposed rule.

We proposed at § 155.210(e)(9)(i) to require Navigators in all Exchanges to help consumers with the process of filing appeals of Exchange eligibility determinations. We did not propose to establish a duty for Navigators to represent a consumer in an appeal, sign an appeal request, or file an appeal on the consumer's behalf. We explained that we believe that helping consumers understand Exchange appeal rights when they have received an adverse eligibility determination, and assisting them with the process of completing and submitting appeal forms, would help to facilitate enrollment and would help consumers obtain fair and impartial information about enrollment, including information about available exemptions from the individual shared responsibility payment that would help consumers decide whether or not to enroll in coverage. We interpreted this proposal to include helping consumers file appeals of eligibility determinations made by an Exchange (including SHOP Exchanges) related to enrollment in a QHP, special enrollment periods, exemptions from the individual shared responsibility payment that are granted by the Exchange, participation as an employer in a SHOP, and any insurance affordability program, including eligibility determinations for Exchange financial assistance, Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Programs.

We also proposed at § 155.210(e)(9)(ii) to require that Navigators in all Exchanges help consumers understand and apply for exemptions from the individual shared responsibility payment that are granted by the Exchange. We explained that this assistance with Exchange-granted exemptions would include informing consumers about the requirement to maintain minimum essential coverage and the individual shared responsibility payment; helping consumers fill out and submit Exchange-granted exemption applications and obtain any necessary forms prior to or after applying for the exemption; explaining what the exemption certificate number is and how to use it; and helping consumers understand and use the Exchange tool to find bronze plan premiums. We explained that this duty would also include explaining the general purpose of Internal Revenue Service (IRS) Form 8965, Health Coverage Exemptions, to consumers, consistent with IRS published guidance on the topic, and explaining how to access this form and related tax information on IRS.gov.

Navigators may not provide tax assistance or interpret tax rules within their capacity as Exchange Navigators, and our proposal would not require Navigators to help consumers apply for exemptions claimed through the tax filing process. We noted that we would, however, interpret the assistance provided under § 155.210(e)(9)(ii) to include helping consumers generally understand the availability of exemptions claimed through the tax filing process and how to obtain them. We noted that this interpretation would help ensure that Navigators share information about the full scope of possible exemptions while not providing actual tax assistance or tax advice. We requested comment on whether we should require that, prior to providing this assistance and information, Navigators provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice within their capacity as Exchange Navigators. We

also sought comment on whether a Navigator's duty to provide assistance with filing exemption applications under proposed § 155.210(e)(9)(ii) and filing appeals of exemption application denials under proposed § 155.210(e)(9)(i) should be limited, in light of the resource limitations that Navigators and their funding agencies may face. We sought comment on whether this assistance should be limited, for example, to consumers who have applied for or have been denied coverage or financial assistance, as opposed to those who only seek to avoid the individual shared responsibility payment, in order not to reduce the assistance available to consumers seeking coverage.

In addition, we proposed at § 155.210(e)(9)(iii) to require Navigators to help consumers with the Exchange-related components of the premium tax credit reconciliation process, such as by ensuring they have access to their Forms 1095–A, Health Insurance Marketplace Statement, and receive general, high-level information about the purpose of this form that is consistent with published IRS guidance on the topic. We explained that under the proposal, Navigators would be required to help consumers obtain IRS Forms 1095–A and 8962, Premium Tax Credit (PTC), and the instructions for Form 8962, and to provide general information, consistent with applicable IRS guidance, about the significance of the forms. Navigators would also be required to help consumers understand (1) how to report errors on the Form 1095–A; (2) how to find silver plan premiums using the Exchange tool; and (3) the difference between advance payments of the premium tax credit and the premium tax credit and the potential implications for enrollment and re-enrollment of not filing a tax return and not reconciling any advance payments of the premium tax credit that were paid on consumers' behalf.

As noted above, Navigators may not provide tax assistance or advice, or interpret tax rules and forms within their capacity as Exchange Navigators, but their expertise related to the consumer-facing aspects of the Exchange, including eligibility and enrollment rules and procedures, uniquely qualifies them to help consumers understand and obtain information from the Exchange that is necessary to the premium tax credit reconciliation process. We indicated that because this proposal would include a requirement that Navigators provide consumers with information and assistance understanding the availability of IRS resources, Navigators would be expected to familiarize themselves with the availability of materials on IRS.gov, including the Form 8962 instructions, IRS Publication 974 Premium Tax Credit, and relevant FAQs, and to refer consumers with questions about tax law to those resources or to other resources, such as free tax return preparation assistance from the Volunteer Income Tax Assistance or Tax Counseling for the Elderly programs.

To help ensure consumers have seamless access to Exchange-related tax information beyond the basic information that Navigators can provide, we proposed at § 155.210(e)(9)(v) that Navigators be required to refer consumers to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and the individual shared responsibility payment, and premium tax credit reconciliation.

We proposed at § 155.210(e)(9)(iv) to require Navigators in all Exchanges to help consumers understand basic concepts related to health coverage and how to use it. We explained that these activities could be supported by existing resources such as the HHS *From Coverage to Care* initiative, which we encouraged Navigators to review, and which is now available in multiple languages at *https://marketplace.cms.gov/c2c*. We explained that this proposal would improve consumers' access to health coverage information both when selecting a plan and when using their coverage. We anticipated that this assistance would vary depending on each consumer's needs and goals.

To ensure that all Navigators receive training in every area for which we proposed a corresponding Navigator duty, we proposed at § 155.210(b)(2)(v) through (viii) to require all Exchanges, including SBEs, to develop and disseminate training standards to be met by all entities and individuals carrying out Navigator functions to ensure expertise in: The process of filing appeals of Exchange eligibility determinations; general concepts regarding exemptions from the requirement to maintain minimum essential coverage and the individual shared responsibility payment, including the application process for exemptions granted through the Exchange, and IRS resources on exemptions; the Exchange-related components of the premium tax credit reconciliation process and IRS resources on this process; and basic concepts related to health coverage and how to use it.

We noted that providing assistance with certain other post-enrollment issues already falls within the scope of existing required Navigator duties. We explained that we interpret the existing requirements to facilitate enrollment in QHPs under section 1311(i)(3)(C) of the Affordable Care Act and § 155.210(e)(3), and to provide information that assists consumers with submitting the eligibility application under § 155.210(e)(2), to include assistance with updating an application for coverage through an Exchange, including reporting changes in circumstances and assisting with submitting information for eligibility redeterminations.

Additionally, we explained in the proposed rule preamble our interpretation that Navigators are already permitted under existing statutory and regulatory provisions to help with a variety of other post-enrollment issues. For example, Navigators may educate consumers about their rights with respect to coverage available through an Exchange, such as nondiscrimination protections, prohibitions on preexisting condition exclusions, and preventive services available without cost sharing. Navigators may also assist consumers with questions about paying premiums for coverage enrolled in through an Exchange and help consumers obtain assistance with coverage claims denials.

We are finalizing the proposals with several modifications to paragraphs (b)(2) and (e)(9). We are revising the requirement that Navigators must provide the post-enrollment and other assistance activities described in § 155.210(e)(9) to give SBEs the option of requiring or authorizing any of these activities, and to make all of these activities required in FFEs under Navigator grants awarded in 2018 or any later year, and optional (but authorized) before then.

We are revising the training requirements under § 155.210(b)(2) to specify that in any Exchange opting to require Navigators to perform any of the assistance topics specified in paragraph (e)(9), the training topic corresponding to the required paragraph (e)(9) assistance topic would also be required. Because all assistance topics specified in paragraph (e)(9) will be required in FFEs under Navigator grants awarded in 2018 or any later year, all training topics will be required in all FFEs under Navigator grants awarded in 2018 or any later year. We are adding a training provision at § 155.210(b)(2)(ix) to ensure

that Navigators who are required under paragraph (e)(9)(v) to provide referrals to licensed tax advisers, tax preparers, or other resources are also trained on this topic.

We are adding language to §§ 155.210(e)(6)(i), 155.215(g)(1), and 155.225(f)(1) to require that, prior to providing assistance, Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors must provide consumers with a disclaimer stating that they are not acting as tax advisers or attorneys when providing assistance as Navigators, non-Navigator assistance personnel, and certified application counselors (respectively), and cannot provide tax or legal advice within their respective capacities as Navigators, non-Navigator assistance personnel, and certified application counselors.

We are also revising the assistance provisions at paragraph (e)(9) as follows:

- To make it more clear that Navigator assistance with Exchange eligibility appeals under paragraph (e)(9)(i) does not require Navigators to help consumers through the entire Exchange eligibility appeals process, we have added the word ''understanding'' to this provision.
- To make minor changes to paragraphs (e)(9)(ii) and (v) to ensure consistent usage of the term ''individual shared responsibility payment,'' and to make a minor change to paragraph (e)(9)(ii) to consistently use the term ''claim'' to describe how consumers apply for exemptions through the tax filing process.
- To remove ''understanding'' from the beginning of paragraph (e)(9)(iii) because we interpret assistance with Exchange-related components of the premium tax credit reconciliation process to also include helping consumers access and use certain Exchange tools and resources, and to add ''understanding'' before ''the availability of IRS resources'' in paragraph (e)(9)(iii) to more clearly specify the type of assistance with IRS resources that is included under this provision.
- To expand the assistance under paragraph (e)(9)(iv), with understanding basic concepts related to health coverage and how to use it, to also include helping consumers understand their rights related to health coverage, and to make a parallel change to the corresponding training topic at paragraph (b)(2)(viii).

Comment: Many commenters supported our proposed additional Navigator duties to provide post-enrollment and other assistance. A number of commenters agreed that assistance beyond enrollment would help Navigators maintain relationships with consumers across coverage years, which may be vital to successful enrollment, reenrollment, coverage utilization, and coverage continuity for some consumers. Several commenters stated that SBEs should have the flexibility to choose whether to require Navigators in their States to perform these additional functions. Other commenters disagreed that post-enrollment assistance falls within Navigators' statutorily authorized duties. One commenter recommended delaying implementation of these requirements for 2 years to give States time to establish and implement training requirements, and to give Navigators time to become familiar with these new requirements. Several commenters recommended making these activities optional for grantees.

Response: We agree that SBEs should have the flexibility to determine effective approaches to post-enrollment and other Navigator assistance based on local experience. For example, some SBEs make the proposed types of assistance available to consumers through different types of community-based consumer advocacy and patient advocacy organizations, and business associations and tax clinics, rather than from Navigators. We do not want to compel SBEs to disrupt or replace successful consumer assistance strategies, and therefore the final rule gives SBEs, including SBE–FPs, the flexibility to decide whether or not they will require or authorize their Navigators to provide any or all of the assistance topics listed at § 155.210(e)(9). Any SBE opting to require its Navigators to provide any or all of the types of assistance listed at § 155.210(e)(9) would also be required to provide training on the corresponding training topics at § 155.210(b)(2)(v) through (ix), and we are modifying the training topic proposals to reflect this policy.

We also agree that a 2-year delay will give FFEs more time to expand coverage of the new assistance topics in the formal FFE training materials, and give FFE Navigators more time to familiarize themselves with the new requirements. Such a delay also aligns with the timing of the next FFE Navigator funding opportunity announcement in 2018 and thus allows 2018 grant applicants to structure their proposals to meet these new requirements while not disrupting current grantee work plans and budgets. Therefore, we are specifying that the new assistance topics and the corresponding training provisions will be required in FFEs beginning with Navigator grants awarded in 2018.

However, we want to emphasize that FFE Navigator grantees will be authorized to provide assistance with any of the topics listed in § 155.210(e)(9) before 2018, when providing assistance in all those topics will be required of them. If FFE Navigator grantees choose to provide any of the assistance specified in § 155.210(e)(9) before 2018, we would expect them to familiarize themselves with related needs in their communities and build competency in the assistance activities they are providing. As we noted in the preamble to the proposed rule, under § 155.215(b)(2), Navigators in FFEs must already be trained on the tax implications of enrollment decisions, the individual responsibility to have health coverage, eligibility appeals, and rights and processes for QHP appeals and grievances. FFE Navigators are also already required under § 155.215(b)(2) to receive training on applicable administrative rules, processes, and systems related to Exchanges and QHPs. HHS will continue to build and improve its training materials in these areas, and in 2018 will expand on the formal FFE Navigator training that HHS already provides on the new assistance topics listed in § 155.210(e)(9). Until then, in addition to HHS's existing formal training, we will continue to provide FFE Navigators with additional information related to the new assistance activities through informal webinars, newsletters, and technical assistance tools like fact sheets and slide presentations. FFE Navigator grantees that opt to carry out any of the assistance activities in § 155.210(e)(9) should draw upon these materials to ensure their staff and volunteers are adequately prepared to provide that assistance.

If SBEs, including SBE–FPs, choose to authorize (but not require) their Navigators to provide the assistance topics listed at § 155.210(e)(9), we would expect them to ensure that their Navigators are sufficiently prepared to provide this assistance, either by including the corresponding training topics at § 155.210(b)(2)(v) through (ix) in their Navigator training standards, or through informal continuing education such as webinars, fact sheets, supplementary trainings and certifications, and other technical assistance. However, because we believe SBEs are in the best position to determine the extent of training that is appropriate for duties they are authorizing (but not requiring) their Navigators to perform, SBEs (including SBE–FPs) would not be required to

provide training on the topics listed in § 155.210(b)(2)(v) through (ix) unless they required the corresponding forms of assistance under § 155.210(e)(9).

Finally, in the preamble to the proposed rule we discussed the statutory authority for the assistance topics specified in § 155.210(e)(9), and we refer commenters to those discussions, at 80 FR 75520–75522.

Comment: Many commenters were concerned that requiring these new duties without additional funding would cause undue burden, discourage program participation, or detract from Navigators' time and resources to help consumers enroll in coverage. Many commenters requested that HHS invest in the Consumer Assistance Programs established under section 2793 of the PHS Act instead of, or in addition to, these requirements.

Response: We expect that providing for SBE flexibility and phasing in implementation of § 155.210(e)(9) in FFEs will mitigate some of commenters' concerns about funding sources. FFE Navigators may cover the costs of these additional activities using Navigator grant funds and will have the opportunity to propose budgets during the grant application process, and current FFE Navigators may revise their work plans if they opt to carry out these activities before they become required.

We agree that Consumer Assistance Programs established under section 2793 of the PHS Act have served an important role for consumers with health insurance concerns. We also remind commenters that § 155.210(e)(4) already requires Navigators in all States to provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under the plan or coverage. Many States operate an office of health insurance consumer assistance or a health insurance ombudsman. The critical assistance provided by these offices will continue to be an important complement to and resource for Navigators, and HHS will continue to explore ways to fund Consumer Assistance Programs. However, we note that this existing referral requirement is not sufficient to cover the new assistance activities under § 155.210(e)(9).

Comment: A few commenters said they believe the proposed Navigator duties duplicate services provided by issuers or agents and brokers. Several commenters requested that Navigators providing post-enrollment assistance be subject to background checks and required to be licensed, carry errors and omissions insurance, and be under the oversight of State regulators.

Response: We believe it is important for consumers to have access to a variety of assistance options. Additionally, Navigators in all States are required under § 155.210(c)(1)(iii) to meet any licensing, certification, or other standards prescribed by the State or Exchange, so long as the standards do not prevent the application of the provisions of title I of the Affordable Care Act.

Comment: A number of commenters supported our proposal that all Exchanges be required to provide training that would prepare Navigators for the additional proposed areas of responsibility. Many commenters urged us to ensure that this training be robust, supported by technical assistance, and carefully monitored and updated. Many commenters suggested that we specify additional training topics. One commenter asked how HHS would ascertain training competency.

Response: We are finalizing the new training provisions largely as proposed, but are adding introductory language so that their applicability is aligned to whether the corresponding assistance activities are required under final § 155.210(e)(9). If an Exchange (including an FFE) opts to require its Navigators to perform any or all of the types of assistance specified in paragraph (e)(9), the Exchange's training standards under paragraph (b)(2) must include corresponding training on any of the required assistance topics. For example, an Exchange opting to require its Navigators to help consumers understand the process of filing Exchange eligibility appeals under § 155.210(e)(9)(i) must ensure its Navigators have expertise in this topic by including the process of filing Exchange eligibility appeals under § 155.210(b)(2)(v) in its training standards. All of the training topics in § 155.210(b)(2)(v) through (ix) must be included in the training standards for Navigators in FFEs under Navigator grants awarded in 2018 or any later year, because that is when all the activities specified under paragraph (e)(9) will be required in FFEs, as discussed above and as specified in paragraph (e)(9). We believe this final policy will ensure that all Navigators required to perform functions under paragraph (e)(9) will be adequately trained in each required topic.

We are also adding a new § 155.210(b)(2)(ix) to correspond to the referral assistance specified in § 155.210(e)(9)(v), and are adding the words ''and rights'' to § 155.210(b)(2)(viii) to parallel a related modification to § 155.210(e)(9)(iv) that is discussed below.

Section 155.215(b)(1)(iii) already requires FFE Navigators, after completing required training, to complete and achieve a passing score on all approved certification examinations prior to carrying out any consumer assistance functions under § 155.205(d) and (e) or § 155.210. FFE Navigators must also obtain continuing education and be certified or recertified on at least an annual basis under § 155.215(b)(1)(iv). Under § 155.210(b)(2), all Exchanges, including SBEs and SBE–FPs, are required to develop training standards that ensure expertise in the topics specified at § 155.210(b)(2), but SBEs, including SBE–FPs, have flexibility in creating examination or certification requirements for their Navigators.

Comment: Many commenters said they do not believe the new Navigator post-enrollment requirements are appropriate for other assister types, such as certified application counselors or non-Navigator assistance personnel subject to § 155.215, who may have more limited time and resources. One commenter thought that these assister types should be encouraged to help consumers understand and use their coverage. Another commenter stated that certified application counselors are well positioned to provide post-enrollment assistance because many are in community health centers. A few commenters recommended that certified application counselors, non-Navigator assistance personnel subject to § 155.215, and Federally Qualified Health Center enrollment counselors should have access to the new Navigator training and resources related to post-enrollment and other assistance.

Response: We agree that non-Navigator assistance personnel subject to § 155.215 and certified application counselors may have more limited resources than Navigators, and that tailoring duties to each of these three assister types fosters a robust pool of different kinds of consumer assistance. Therefore, we are not finalizing any assistance or training requirements parallel to § 155.210(b)(2)(v)–(ix) and (e)(9) for non-Navigator assistance personnel subject to § 155.215 or certified application counselors. As we noted in the preamble to the proposed rule, the requirement under § 155.210(e)(2) to provide information that assists consumers with submitting the eligibility application (which also applies to certain non-Navigator

assistance personnel through § 155.215(a)(2)(i)), could include helping consumers report changes in circumstances and submit information for eligibility redeterminations. We also noted in the preamble to the proposed rule that under § 155.215(b), non-Navigator assistance personnel subject to § 155.215 and Navigators in FFEs are subject to the same training requirements. In addition, all FFE training modules can be accessed by the public, including by certified application counselors and non-Navigator assistance personnel subject to § 155.215. As noted in the preamble to the proposed rule, nothing prevents non-Navigator assistance personnel subject to § 155.215 or certified application counselors from helping with activities that are consistent with their existing regulatory duties.

Although we are not requiring any assistance or training requirements parallel to the new provisions under § 155.210(b)(2)(v) through (ix) and (e)(9) for non-Navigator assistance personnel subject to § 155.215 or certified application counselors, we believe that a disclaimer stating that these assisters are not acting as tax advisers or attorneys (as discussed below) is an important consumer protection that should apply regardless of whether these assisters are providing assistance on the topics specified at § 155.210(e)(9). For this reason, and to align parallel provisions requiring Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors to provide consumers with information about their respective functions and responsibilities, we are revising §§ 155.215(g)(1) and 155.225(f)(1) to require that, prior to providing assistance, non-Navigator assistance personnel subject to § 155.215 and certified application counselors provide consumers with a disclaimer stating that they are not acting as tax advisers or attorneys when providing assistance (respectively) as non-Navigator assistance personnel and certified application counselors, and cannot provide tax or legal advice within their (respective) capacities as non-Navigator assistance personnel and certified application counselors.

Comment: A number of commenters cautioned that Navigators should not be expected to become, or be held out as, experts in the new assistance topics specified in § 155.210(e)(9). Several commenters asked that we further define what we mean by ''assistance with'' so that Navigators can be clear about the full extent of consumer support expected from them in these areas.

Response: Each Navigator grantee and each individual Navigator should have the ability to help any individual who presents themselves for assistance. Additionally, we expect that all individuals carrying out Navigator duties would be trained to perform all of the duties of a Navigator and would be equipped to assist consumers with the activities described in § 155.210(e)(9) in Exchanges where the activities described in § 155.210(e)(9) are required or authorized. Below, we discuss examples of the kinds of assistance we interpret § 155.210(e)(9) to include.

Comment: Several commenters asked us to explain whether Navigators are permitted to collect, disclose, access, maintain, store or use personally identifiable information (PII) to carry out these additional duties. One commenter asked us to explain how consumer privacy protections will be ensured and enforced.

Response: Under their grant terms and conditions, FFE Navigators are permitted to create, collect, handle, disclose, access, maintain, store, or use consumer PII only to perform functions that they are authorized to perform under the terms of their grant, including functions authorized or required under § 155.210, or for other purposes for which the consumer provides his or her specific, informed consent. Once this rule takes effect, the activities under paragraph (e)(9) will be authorized Navigator functions in FFEs, both before and after 2018. Therefore, after this rule takes effect, FFE Navigators may create, collect, handle, disclose, access, maintain, store, and use consumer PII to perform these functions, and we will update guidance and model consent forms to reflect this. HHS has a variety of enforcement options in the event of a violation of these standards, including implementing corrective action plans or pursuing civil money penalties under § 155.206 or § 155.285, or withholding or terminating grant funds. With respect to SBEs, § 155.260(b) directs SBEs to execute a contract or agreement with Navigators that binds them to privacy and security standards that, among other things, take into consideration a Navigator's authorized duties and activities. If an SBE opts to require or authorize the activities specified in § 155.210(e)(9) after that provision takes effect, we would expect that SBE privacy and security standards would reflect SBEs' decisions to require or authorize Navigators to carry out these additional activities, and would give Navigators the ability to create, collect, handle, disclose, access, maintain, store, and use PII as needed to do so. In any event, the exact extent to which and the conditions under which each SBE may permit or require its Navigators to create, collect, handle, disclose, access, maintain, store, and use PII is a matter within the reasonable discretion of the SBE, so long as the SBE's standards comply with § 155.260 and otherwise do not act as an impediment to the performance of required or authorized Navigator duties under § 155.210.

Comment: We asked for comment on whether we should make explicit in the regulation any of our interpretations of existing statutes and regulations that would permit (but not require) Navigators to perform certain kinds of post-enrollment assistance, such as assistance with coverage claims denials. We also asked for comment on whether there are additional forms of post-enrollment assistance that Exchanges should require Navigators to provide, commensurate with their general legal authority. One commenter recommended that we specify in regulation any Navigator activities we interpret to be permitted but not required. Some commenters recommended that additional post-enrollment activities should be required, including filing complaints with regulators, assisting pregnant women enrolled in QHPs to understand their coverage options and ensure continuity of coverage, and helping enrollees pursue coverage determination appeals and formulary exceptions.

Response: Because we are sensitive to the concerns commenters expressed about Navigators' limited time and resources to perform the new activities described in § 155.210(e)(9), we are not adding provisions that require or permit any additional activities commenters recommended at this time. Instead, we have tried to limit the modifications to the proposed activities in this final rule to changes that provide additional detail about the scope of the specific post-enrollment and other new assistance activities that we proposed adding to the rule.

Comment: With respect to our proposed requirement that Navigators provide information and assistance with filing Exchange eligibility appeals, many commenters were concerned that consumers' legal rights may be compromised without proper legal representation, and stated that Navigators should serve primarily as a bridge to connect consumers with legal assistance. One commenter stated that Navigators should have the option of assisting consumers with appeals only when they have the expertise to do so.

Several asked us to clarify that Navigators may not serve as authorized representatives for consumers filing appeals. Commenters urged HHS to clearly define the types of information Navigators must provide related to appeals and create guidelines to help Navigators and consumers recognize where legal assistance becomes appropriate or necessary. Several commenters recommended that this duty be limited to making consumers aware of their right to appeal, providing basic education on the appeals process, and making appropriate referrals for legal assistance when possible. To facilitate these referrals, commenters asked HHS to help FFE Navigator grantees identify methods of establishing relationships with local legal services organizations and other State offices to help with the appeals process. One commenter suggested that Navigators should also provide information and assistance with appeal denials. One commenter asked how these proposed requirements might affect Medicaid appeals in States that have delegated the authority to make Medicaid and CHIP eligibility determinations to the Exchange. A number of commenters interpreted our proposal to mean that Navigators would be required to help consumers appeal adverse coverage decisions.

Response: We recognize that helping consumers through the entire Exchange appeals process may require more resources and expertise than many Navigators can offer. To that end, we are narrowing this provision by adding the word ''understanding'' to make clear that any assistance required under this provision is limited to activities that help consumers understand the process of filing Exchange eligibility appeals, and does not include a requirement to help consumers through the entire Exchange eligibility appeals process. It does not prevent Navigators who are authorized or required to provide assistance under this provision from providing such longer-term assistance, as long as they do not provide legal advice in their capacity as Navigators, as discussed below. We also appreciate the critical and established role that legal services organizations play in helping consumers understand and access their Exchange eligibility appeal rights, and have incorporated providing information about free and low-cost legal help into our expectations for assistance under this provision, as discussed below.

We interpret assistance under this provision to include the following activities, as relevant to consumers' needs: (1) Helping consumers identify and meet the deadline for appealing an Exchange eligibility determination; (2) helping consumers understand that they have a right to appeal eligibility determinations made by an Exchange (including SHOP Exchanges) related to enrollment in a QHP, special enrollment periods, exemptions from the individual shared responsibility payment that are granted by the Exchange, participation as an employer in a SHOP, and any insurance affordability program, including eligibility determinations for Exchange financial assistance, Medicaid, the Children's Health Insurance Program, and Basic Health Programs; (3) helping consumers understand the process of appealing those eligibility determinations and what steps to take to complete an appeal; (4) helping consumers access relevant Exchange resources, such as appeal request forms and mailing addresses for appeals, and Exchange guidance on appeals; and (5) providing consumers with information about free or low-cost legal help in their area, including local legal aid or legal services organizations and other State offices to help with the Exchange eligibility appeals process. Assistance under this provision may also include helping consumers collect supporting documentation for the appeal (such as screenshots of relevant information from the online application).

Although the assistance under § 155.210(e)(9)(i) includes helping consumers understand the general availability of a right to appeal adverse Exchange eligibility determinations and the process for appealing them, Navigators should not, in their capacity as Navigators, cross the line into providing legal advice, such as by recommending that consumers take specific action with respect to that right. For example, Navigators could help consumers understand the difference between an appeal and an expedited appeal, but should not help them decide which one is best suited to their circumstances. We suggest that Navigators familiarize themselves with any laws defining legal advice in the States in which they operate, as this may help them ascertain when they might be taking an action that could constitute providing legal advice. We also note that we did not propose nor are we establishing a duty for Navigators to represent a consumer in an appeal, sign an appeal request, or file an appeal on the consumer's behalf, either as a legally authorized representative or otherwise. Although HHS regulations do not prohibit Navigators from serving as authorized representatives under § 155.227 outside of their capacity as Navigators, they should keep any activities as a consumer's authorized representative separate from their Navigator duties and should not use Navigator grant funds for these activities, because these activities are not authorized Navigator functions under HHS regulations.

Assistance provided under this provision does not include assistance with appeals of coverage decisions by issuers, but only assistance with appeals of eligibility determinations made by an Exchange. However, as we said in the preamble to the proposed rule, Navigators are already permitted, but not required, to help consumers obtain assistance with coverage claims denials and to educate consumers about their rights with respect to coverage available through an Exchange. Additionally, under the new language about rights that we are adding to § 155.210(e)(9)(iv), Navigators providing assistance under that paragraph should inform consumers who have questions about coverage claims denials that they have the right to appeal adverse benefit determinations and to have the appeal reviewed by an independent third party. Finally, as indicated above, helping consumers with the process of filing Exchange eligibility appeals includes, where applicable, helping consumers understand the process of filing an appeal of a modified adjusted gross income (MAGI)-based Medicaid or CHIP eligibility determination, where the State has delegated authority to the Exchange to adjudicate these appeals.

Comment: Commenters supported our proposals to require Navigators to provide consumers with information and assistance regarding exemptions. One commenter disagreed with our proposal, arguing that exemptions assistance is counter to the goal of the Affordable Care Act. The majority of commenters recommended exemptions assistance not be limited to certain consumers because helping with exemptions is minimally burdensome and because of the importance of skilled assistance to consumers who cannot access coverage. Several commenters suggested that Navigators should have the flexibility, if they are unable to fully meet consumer demand, to prioritize helping consumers apply for and enroll in coverage over helping consumers seek exemptions during open enrollment. Several commenters recommended that this duty include assistance with understanding the requirement to maintain minimum essential coverage and the individual shared responsibility payment, the general purpose of and where to access

IRS Form 8965, Health Coverage Exemptions, and how to use applicable Exchange tools to find bronze plan and second-lowest cost silver plan premiums. Several commenters recommended that Navigators' duty with respect to exemptions should be limited to education about, but not assistance with, obtaining an exemption. One commenter asked for guidance on how this requirement would apply to SBE Navigators, since most States' Exchange-granted exemptions are processed by an FFE, rather than an SBE.

Response: We are not limiting Navigator assistance with exemptions under paragraph (e)(9)(ii) to a specific consumer population because we agree that Navigator services should not be exclusively available to a predefined set of consumers and closed to others. Where resources are limited, Navigators providing assistance under this provision may prioritize helping consumers seeking to apply for and enroll in coverage. For example, during a busy enrollment event, Navigators may choose to limit exemptions assistance to directing consumers to exemptions resources on HealthCare.gov and IRS.gov, and schedule another time for consumers to return for additional assistance. But we also continue to expect that Navigators will serve all consumers seeking assistance.

We believe that the Affordable Care Act contemplates that Navigators will assist consumers with making an informed decision about whether to enroll in health coverage, and making this decision will often require consumers to have a basic understanding of available exemptions. We are finalizing § 155.210(e)(9)(ii) generally as proposed, except that for clarity and consistent use of terminology we are modifying the reference to the individual shared responsibility requirement to refer to the individual shared responsibility payment, and are changing language about ''how to apply for'' exemptions claimed through the tax filing process to ''how to claim'' them. Because exemptions assistance needs will vary among consumers, and to avoid being overly prescriptive, we are not expanding the assistance specifically required under this provision to include the activities recommended by commenters. We interpret assistance under this provision to include the following activities, as relevant to consumers' needs: (1) Informing consumers about the requirement to maintain minimum essential coverage and the individual shared responsibility payment; (2) helping consumers fill out and submit Exchange-granted exemption applications and obtain any necessary forms prior to or after applying for the exemption; (3) explaining what the exemption certificate number is and how to use it; (4) helping consumers understand the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to claim them; (5) helping consumers use any applicable Exchange tool to find lowest cost bronze and second-lowest cost silver plan premiums (that is, the FFE tool or any similar tool offered by an SBE); and (6) helping consumers understand the availability of IRS resources on this topic, including explaining the general purpose of and how to access IRS Form 8965, Health Coverage Exemptions, and the instructions for that form. We emphasize that explaining the general purpose of IRS Form 8965 to consumers must be done consistent with IRS published guidance on the topic, and must include providing information on where to access this form and related tax information on IRS.gov.

With respect to exemptions granted through the Exchange, we do not believe that Navigators' activities related to exemptions should be limited to education only. However, to help ensure that Navigators do not provide tax advice in their capacity as Navigators, we are finalizing the portion of this proposal that limits Navigators' required involvement in exemptions claimed through the tax filing process to providing general information and helping consumers access IRS resources, rather than assistance with claiming exemptions on the tax return or filling out IRS forms. For example, Navigators acting in their capacity as Navigators must not help consumers fill out IRS Form 8965 or help them report having minimum essential coverage on their tax return. We believe this limitation is sufficient to protect both consumers and Navigators.

In any SBEs that opt to require or authorize this assistance, Navigators will be required or authorized (respectively) to help consumers access Exchange-granted exemptions, whether consumers in that State access those exemptions through the SBE or FFEs, and, as in any Exchange, they will be limited to providing only general information about exemptions claimed on the tax return in their capacity as Navigators.

Comment: Many commenters said that Navigators should provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice within their capacity as Navigators. One commenter stated that requiring a disclaimer was unnecessary because Navigators do not provide tax advice and many already provide a disclaimer to this effect. Some commenters recommended that we require a similar disclaimer that Navigators are not acting as legal representatives and cannot provide legal advice or legal representation within their capacity as Navigators. Some commenters recommended that the disclaimer be required to be written, provided in a linguistically appropriate manner, or included in our model authorization form for FFE Navigators.

Response: We agree that prior to providing assistance, Navigators should provide consumers with a disclaimer stating that they are not acting as tax advisers or attorneys when providing assistance as Navigators, and cannot provide tax or legal advice in their capacity as Navigators. We are therefore adding language to § 155.210(e)(6)(i) to specify that such a disclaimer must be included as part of the information provided to applicants about the Navigator's functions and responsibilities and that both the disclaimer and the information provided about Navigator functions and responsibilities must be provided prior to providing assistance. We do not interpret this requirement to mean that Navigators must provide such a disclaimer prior to providing general outreach and education. Although we do not specify the method of delivering the disclaimers, we plan to add these disclaimers to our model authorization form for FFE Navigators. The requirement under § 155.210(e)(5) that Navigators must provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange and accessible to people with disabilities will apply to these disclaimers. Finally, as discussed above, we are adding a parallel disclaimer requirement for non-Navigator assistance personnel subject to § 155.215 and certified application counselors, under §§ 155.215(g)(1) and 155.225(f)(1) (respectively).

Comment: Many commenters supported our proposal to require Navigators to provide consumers with assistance with understanding the Exchange-related components of the premium tax credit reconciliation process, and the availability of IRS resources on this process. Commenters agreed that although Navigators should not provide tax advice, informing

consumers of the tax implications of receiving advance payment of the premium tax credit is an essential component of helping consumers enroll. Several commenters recommended that we specify that this assistance entails helping consumers: (1) Access and understand IRS Forms 1095–A, –B, and –C, (2) understand how to report Form 1095 errors, (3) understand how to use applicable Exchange tools to find silver plan premiums, and (4) understand the purpose of IRS Form 8962. A few commenters suggested that Navigators should also provide information about reliable resources on this process from sources other than the IRS. Other commenters were concerned that our proposal would stretch Navigators' capacity and distract from enrollment, and that tax professionals, not Navigators, are best suited to assist consumers with tax-related issues. Some commenters asked us to clarify the prohibition on providing tax advice, one commenter requested that we add this prohibition to § 155.210(d), and another asked how it will be enforced.

Response: We are finalizing this provision largely as proposed. Because not all consumers will require information and assistance with each of the topics commenters recommended that we include in this provision, we are not expanding the final rule to include them. However, we interpret assistance under this provision to include helping consumers with the following, as relevant to their needs: (1) The Exchange-related components of the premium tax credit reconciliation process; (2) accessing and understanding the general purpose of IRS Form 1095–A; (3) understanding how to report Form 1095–A errors; (4) using any applicable Exchange tool to find second-lowest cost silver plan premiums (that is, the FFE tool or any similar tool offered by an SBE); and (5) understanding the availability of IRS resources on this process, including the general purpose of and how to access IRS Form 8962, and the instructions for that form. To avoid confusion about the scope of this provision, we are removing the word ''understanding'' from the beginning of the provision, because Navigators' assistance with the Exchange-related components of the premium tax credit reconciliation process would include not only helping consumers understand Exchange tools and resources but also helping consumers access and use these tools and resources. We are also adding ''understanding'' before the provision's description of Navigators' assistance with respect to the availability of IRS resources on this process, to better capture our interpretation that Navigators are not authorized to interpret those resources, and can instead only direct consumers to them. This edit also helps align this provision with the similar requirement in § 155.210(e)(9)(ii) that Navigators help consumers understand the availability of IRS resources on exemptions.

Where Navigators are also tax professionals, they might be in a position to assist clients with both the Exchange-related and the tax filing components of the premium tax credit reconciliation process, but should keep these duties separate and not perform any tax assistance within their capacity as Navigators or using Navigator grant funds. As part of Navigators' assistance with Form 1095–A, they may, for example, explain to consumers why they received the form and what the information on the form means, explain why they may have received more than one copy of the form, help them find the form in their online account or get a copy of the form, explain what they should do if they think the form may have gone to the wrong address, or if they think the information on their form is incorrect or does not include a dependent they added to their coverage. On the other hand, Navigators who are acting in their capacity as Navigators should not, for example, help consumers fill out IRS Form 8962, advise consumers about whether to file an amended tax return, or help them complete their income tax return. We believe it is critically important to ensure that consumers are provided with the most authoritative, accurate, and up-to-date resources related to premium tax credit reconciliation, and thus IRS-approved resources must be the primary resource to which Navigators refer consumers.

We disagree with commenters that Navigators should be required to help consumers access and understand IRS Forms 1095–B and 1095–C. Form 1095–B, Health Coverage, is an annual form issued by providers of minimum essential coverage to report certain information to the IRS and to taxpayers about individuals who had coverage during the year. Form 1095–C, Employer-Provided Health Insurance Offer and Coverage, is an annual form issued by certain large employers to report to the IRS and to taxpayers information about offers of employer-sponsored coverage for the year. Unlike the Form 1095–A, these forms are not issued by an Exchange. The IRS has resources that explain the purpose of these forms, how they relate to the tax filing process, how to request copies of the forms, and how to request corrections to the forms. Navigators should be able to help consumers access IRS resources relating to these forms. However, we are not requiring Navigators providing assistance under this provision to help consumers access these forms or report errors.

Comment: We received support from commenters for our proposal to require Navigators to help consumers understand basic concepts related to health coverage and how to use it. Several commenters recommended that this assistance include helping consumers understand their rights related to health coverage. Some recommended that we specify topics in addition to the examples we included in the preamble to the proposed rule, including helping consumers understand out-of-pocket cost calculators and provider and formulary lookup tools, common utilization management definitions, including step therapy and prior authorization, and what an Explanation of Benefits Statement is and how to read it. Other commenters stated that because this assistance will vary depending on each consumer's health insurance literacy, needs, and goals, additional specificity is unnecessary.

Response: We agree with commenters that consumers' rights with respect to coverage available through an Exchange, such as nondiscrimination protections and prohibitions on preexisting condition exclusions, are critical for consumers to understand when accessing or attempting to access coverage through an Exchange. Additionally, in the preamble to the proposed rule, we explained that the assistance provided under this provision could include helping consumers understand the right to coverage of certain preventive health services without cost sharing, and that we interpret existing HHS regulations to permit Navigators to educate consumers about their rights with respect to coverage available through an Exchange. Therefore, we are adding the phrase ''and rights'' to § 155.210(e)(9)(iv) to ensure that Navigators' activities in this area include education about these topics. However, to avoid crossing the line into providing legal advice, Navigators should not, in their capacity as Navigators, recommend that consumers take specific action with respect to these rights. We are also adding the phrase ''and rights'' to the corresponding training provision related to this duty at § 155.210(b)(2)(viii). Because the health literacy information consumers need varies depending on their circumstances, we are not

requiring Navigators to help consumers with specific health literacy topics. Instead, we interpret assistance under this provision to include, for example, helping consumers understand: (1) Key terms used in health coverage materials, such as ''deductible'' and ''coinsurance,'' and how they relate to the consumer's health plan; (2) the cost and care differences between a visit to the emergency department and a visit to a primary care provider under the coverage options available to the consumer; (3) how to identify in-network providers and how to make and prepare for an appointment with a provider; (4) how the consumer's coverage addresses steps that often are taken after an appointment with a provider, such as making a follow-up appointment and filling a prescription; and (5) the right to coverage of certain preventive health services without cost sharing.

Comment: A few commenters asked for clarification about whether the duty proposed in § 155.210(e)(9)(iv) pertains to general education about health coverage or to assisting individuals with activities such as making appointments or filling prescriptions, which they believed would be overly burdensome. Several commenters stated that there are insufficient educational resources available and asked HHS to create template materials and identify other resources on these topics. One commenter asked HHS to undertake or support a thorough assessment of consumer health insurance literacy needs. Some commenters noted that issuers often provide additional training and materials to agents and brokers about their plans, and recommended that HHS require issuers to provide Navigators with this kind of information.

Response: The assistance provided under § 155.210(e)(9)(iv) only includes providing information and assistance with *understanding* basic concepts and rights related to health coverage and how to use it; it does not include patient advocacy or case management. With respect to needs assessments, we remind Navigators in FFEs of their obligations under § 155.215(c)(1) to develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's health literacy and other needs, and under § 155.215(c)(2) to collect and maintain updated information to help understand the composition of the communities in the service area.

Agents and brokers often receive information on health plans from the issuers with whom they have a contractual relationship. While we do not require QHP issuers to provide their affiliated agents and brokers with plan information, we continue to leverage existing practices and encourage agents and brokers to work directly with QHP issuers within whom they have a contractual relationship to obtain the necessary information on that issuer's QHPs. Navigator organizations may invite issuers in their area to share information or attend education sessions regarding plan benefits and details. As long as all issuers in the Exchange service area are invited and all applicable Navigator conflict-of-interest provisions are followed, including the rule prohibiting Navigators from receiving any consideration directly or indirectly from any health insurance issuer or stop-loss insurance issuer in connection with the enrollment of any individuals or employees in a QHP or non-QHP, such an event would not represent a conflict of interest or violate a Navigator's duty under § 155.210(e)(2) to provide information and services in a fair, accurate, and impartial manner.

Comment: Most commenters supported our proposal that Navigators be required to provide referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility requirement, and premium tax credit reconciliations. Commenters requested detail about how such a referral mechanism would work; for example, whether Navigators would be allowed to refer consumers to a specific tax professional, as opposed to a general listing of tax professionals. Other commenters asked HHS for guidance on limitations and strategies for referring and collaborating with tax preparation services, legal services organizations, community experts, patient-focused and community-based organizations, and other State offices. One commenter questioned the term ''licensed tax adviser,'' noting that IRS does not provide such a license. Another asked HHS to specify IRS's Volunteer Income Tax Assistance (VITA) and Tax Counseling for the Elderly (TCE) programs as appropriate points of referral. And one commenter asked HHS to partner with the Internal Revenue Service (IRS) to provide training and education to tax preparers.

Response: All referrals from a Navigator to other organizations must be consistent with applicable statutory and regulatory requirements, including the requirement at § 155.210(e)(2) that Navigators provide information and services in a fair, accurate, and impartial manner, and the conflict of interest provision at § 155.210(d)(4) prohibiting Navigators from receiving any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP. We interpret the requirement under § 155.210(e)(2) that Navigators provide information and services in a fair, accurate, and impartial manner to mean that Navigators must not accept payment in exchange for providing a referral or recommending the services of another organization. We intend to issue guidance for FFE Navigators with additional information on collaborating or partnering with other organizations.

The referrals discussed under this provision include referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice. Licensed tax advisers are one type of tax professional, but not the only type. ''Licensed'' can mean any type of professional license that qualifies someone to prepare taxes, and could include certified public accountants and attorneys. We agree that VITA and TCE programs may often be the best resources for referral under this provision.

To ensure that Navigators who are required under paragraph (e)(9) to provide referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice are also trained on this topic, we are adding a corresponding training provision at § 155.210(b)(2)(ix). We are also replacing a reference in paragraph (e)(9)(v) to the individual shared responsibility requirement with a reference to the individual shared responsibility payment, to ensure consistent use of terminology.

We also proposed to amend §§ 155.205(d) and 155.215(b)(1)(i) to specify that any individual or entity carrying out consumer assistance functions under § 155.205(d) and (e) or § 155.210, in both SBEs and FFEs, would be required to complete training prior to performing any assister duties, including before conducting outreach and education activities, as well as before providing application and enrollment assistance. Section 155.215(b) already requires Navigators and non-Navigator assistance personnel in FFEs and non-Navigator assistance personnel funded through Exchange Establishment grants under section

1311(a) of the Affordable Care Act to obtain certification by the Exchange prior to carrying out any consumer assistance functions under § 155.205(d) and (e) or § 155.210. We proposed to amend § 155.215(b)(1)(i) to specify that the consumer assistance functions referenced in that provision would include outreach and education activities. In addition, we proposed to amend § 155.205(d) to require that training be completed not only before providing the assistance described in that paragraph, but also before conducting the outreach and education activities specified in paragraph (e).

This proposal sought to ensure that individuals and organizations subject to §§ 155.205(d) and (e), 155.210, and 155.215 do not perform any Exchange outreach and education activities or application and enrollment assistance while identifying as or holding themselves out to the public as Exchange-approved Navigators or non-Navigator assistance personnel, prior to completing Exchange requirements, including training and certification. The proposed amendments would not apply to certified application counselors, but § 155.225(d)(1) already requires certified application counselors to complete and achieve a passing score on all Exchange approved certification examinations prior to functioning as certified application counselors.

We are finalizing these amendments as proposed.

Comment: The majority of commenters supported our proposal to require that Navigators and non-Navigator assistance personnel complete training prior to performing any assister duties, including before conducting outreach and education activities, as well as before providing application and enrollment assistance. These commenters also recommended exempting Navigators in FFEs and non-Navigator assistance personnel subject to § 155.215 who are eligible to be recertified from the requirement in § 155.215(b) to complete recertification training prior to conducting outreach and education. A few commenters expressed concern regarding the availability and content of training. Commenters also were concerned that this provision would prevent Navigators and non-Navigator assistance personnel subject to § 155.215 from conducting year-round outreach education, if training is not available year round, or recommended that training be available at least 2 months prior to open enrollment so that new assisters subject to this requirement can complete the training and begin assisting consumers.

Response: We appreciate the support for this proposal and agree that it is essential that consumers trust that Navigators and non-Navigator assistance personnel are properly informed and trained when consumers seek out their services, whether those services include assistance with an Exchange application or education about the Exchange. We recognize commenters' concerns that the timing of the FFE Navigator and non-Navigator assistance personnel training may prevent some Navigators and non-Navigator assistance personnel in FFEs from conducting outreach and enrollment work during periods when training is being updated and relaunched prior to the start of a new open enrollment period for the individual market. We will continue to strive to complete FFE training updates prior to FFE Navigator and non-Navigator assistance personnel certification deadlines. We believe there is great value in ensuring that Navigators in FFEs and non-Navigator assistance personnel subject to § 155.215 complete recertification training prior to providing any outreach or assistance to consumers because there are often changes in Exchange operations and policy from year to year and we want to ensure that these assisters are providing the most up to date and accurate information to consumers. Therefore, we are not exempting Navigators in FFEs and non-Navigator assistance personnel subject to § 155.215 who are eligible to be recertified from this requirement.

Comment: A few commenters requested clarification regarding individuals who are not yet certified or are not acting as Navigators or non-Navigator assistance personnel at Navigator and non-Navigator assistance personnel organizations but who may be serving as spokespeople and conducting public education activities about the Exchange and the Exchange assistance available from the organization. One commenter requested that HHS allow newly hired, but not fully trained or certified Navigators to conduct outreach, as long as they disclose they are not yet certified to conduct enrollment assistance and immediately refer consumers to a fully trained and certified Navigator. A few commenters opposed our proposal due to concern that it would prohibit such activities.

Response: As explained in the proposed rule preamble, nothing in the Exchange regulations prohibits individuals who are not trained and certified as Exchange-approved Navigators, non-Navigator assistance personnel, or certified application counselors from conducting outreach about Exchanges and providing application and enrollment assistance. These individuals may of course conduct outreach and education about Exchanges as long as they do not represent themselves as Exchange-approved Navigators, non-Navigator assistance personnel, or certified application counselors.

Comment: One commenter expressed concern about how this provision could reasonably be enforced.

Response: Exchanges have discretion to pursue a variety of enforcement options in the event of Navigator or non-Navigator assistance personnel noncompliance with any applicable statutory or regulatory requirements or prohibitions. These options include implementing corrective action plans or pursuing civil money penalties under § 155.206 or withholding or terminating grant or contract funds. FFE Navigators and FFE non-Navigator assistance personnel who wish to file a complaint or grievance against other FFE Navigators or FFE non-Navigator assistance personnel can contact their Project Officer or point of contact at CMS. FFE certified application counselors should direct complaints or grievances to the certified application counselor inbox at *CACQuestions@cms.hhs.gov.* We also rely on communication with State regulatory agencies (such as Departments of Insurance) and CMS Regional Offices regarding FFE Navigator and FFE non-Navigator assistance personnel conduct.

Section 155.210(d)(6) currently prohibits Navigators from providing to an applicant or potential enrollee any gifts unless they are of nominal value; or any promotional items that market or promote the products or services of a third party, when those promotional items are being used as an inducement for enrollment. Through a cross-reference to § 155.210(d) in § 155.215(a)(2)(i) and a parallel provision in § 155.225(g)(4), this prohibition also applies to non-Navigator assistance personnel subject to § 155.215, and to certified application counselors.

To reduce confusion about when gifts and promotional items can be provided to applicants and potential enrollees, we proposed to amend §§ 155.210(d)(6) and 155.225(g)(4) to specify that gifts of any value (including third-party promotional items of any value) should never be provided to applicants or potential enrollees as an inducement for enrollment. We also proposed to specify that gifts that are not provided as an inducement for enrollment may be provided to applicants and potential enrollees if they do not exceed nominal

value.[40] We proposed that this nominal value restriction would apply both to each individual gift and to the cumulative value of multiple gifts, including promotional items. We further proposed that the nominal value restriction on the cumulative value of multiple gifts would only apply to single encounters between the assister and an individual, and not to multiple encounters, so that assisters would not have to collect PII as a means of tracking the number and value of gifts provided to an individual consumer across multiple encounters, such as all encounters in a single calendar year or enrollment season. We noted that we would consider a single outreach or educational event to be a ''single encounter''; that is, the assisters subject to the proposed requirement would not be permitted to provide multiple gifts to the same consumer at the same outreach event if the cumulative value of those gifts exceeded nominal value.

We proposed to define ''gifts,'' for purposes of §§ 155.210(d)(6) and 155.225(g)(4), to include gift items, gift cards, cash cards or cash, as well as promotional items that market or promote the products or services of a third party. Language in §§ 155.210(d)(6) and 155.225(g)(4) currently provides that gifts, gift cards, or cash may exceed nominal value for the purpose of providing reimbursement for legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses. We proposed to amend this language to indicate that the reimbursement of legitimate expenses, such as travel and postage expenses, when incurred by a consumer in an effort to receive Exchange application assistance, would not be considered a gift, and therefore, would not be subject to the proposed restrictions on providing gifts.

Finally, existing regulations under §§ 155.210(d)(7) and 155.215(a)(2)(i) already prohibit the use of Exchange funds by Navigators and by non-Navigator assistance personnel subject to § 155.215 to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee. We did not propose to amend this provision.

[40] We have previously defined ''nominal value'' as a cash value of $15 or less, or an item worth $15 or less, based on the retail purchase price of the item, regardless of the actual cost. (79 FR 15807, 15831 (Mar. 21, 2014) and 79 FR 30239, 30283 (May 27, 2014).

We are finalizing the amendments to §§ 155.210(d)(6) and 155.225(g)(4) as proposed.

Comment: Many commenters supported our proposals, agreeing that the amendments clarify the rule and strike the right balance between allowing Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors to use gifts and promotional items in outreach while ensuring they are never used to induce enrollment. Some commenters asked for examples of permissible and impermissible gifts, promotional items, and legitimate expenses. Several commenters asked for guidance on the terms ''nominal'' and ''products or services of a third party.'' One commenter suggested that our rule may conflict with the beneficiary inducement rules that apply to Medicare and State health care programs, potentially creating difficulties for Navigators that are health care providers.

Response: As we noted in the preamble to the proposed rule, we have previously defined ''nominal value'' as a cash value of $15 or less, or an item worth $15 or less, based on the retail purchase price of the item, regardless of the actual cost (79 FR 15831 and 79 FR 30283). This nominal value limit applies to all gifts, including gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party. Some illustrative examples of permissible gifts and promotional items include pens, magnets, or key chains worth $15 or less each, including if such items bear the name or logo of a local business, or community or social service program. Such items may, for example, be provided to consumers at outreach and education events or at other forums attended by members of the general public, as long as they are not being provided as an inducement to enrollment. By ''inducing enrollment,'' we mean conditioning receipt of the items on a consumer's actually enrolling in coverage, as opposed to encouraging consumers to seek or receive application or other authorized assistance. To the extent that Federal or State health program beneficiary inducement rules apply to entities or individuals who also serve as Navigators, non-Navigator assistance personnel subject to § 155.215, or certified application counselors, those entities and individuals must comply with those rules as well as the applicable program rules under §§ 155.210(d)(6), 155.215(a)(2)(i), and 155.225(g)(4).

d. Ability of States To Permit Agents and Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

We proposed additional standards under § 155.220 for oversight and enforcement of standards applicable to agents, brokers, and web-brokers who facilitate enrollment in the FFEs. These standards were proposed under the Secretary's authority to establish procedures for States to permit agents and brokers to assist consumers enrolling in QHPs through the FFEs, as described in sections 1312(e) of the Affordable Care Act.

In the proposed rule, we explained that we were considering an option to enhance the direct enrollment process, so that an applicant who initiated enrollment directly with a web-broker entity using the web-broker's non-Exchange Web site could remain on the web-broker's Web site to complete the application and enroll in coverage, instead of being redirected to the Exchange Web site to complete the application and receive an eligibility determination. Under the proposal, the web-broker's Web site could obtain eligibility information from the Exchange to support the consumer in selecting and enrolling in a QHP with Exchange financial assistance. Accordingly, we proposed to revise § 155.220(c)(1) to ensure that the Exchange maintained its role in determining eligibility when an applicant initiates enrollment with a web-broker on the web-broker's non-Exchange Web site, by requiring the agent or broker to ensure that the applicant completed an eligibility verification and enrollment application through the Exchange Web site, or an Exchange-approved web service using the FFE single streamlined application. Additionally, we solicited comments on the proposal to require web-broker entities to use the FFE single streamlined application without deviation from the language of the application questions and the sequence of information required for an eligibility determination or redetermination. We solicited comments on how much flexibility web-broker entities should be afforded relative to the consumer experience on its non-Exchange Web site. We also sought comment on additional matters HHS should consider to improve the direct enrollment process, such as requiring HHS approval of alternative enrollment pathway processes, additional consumer safeguard protections, additional web-broker reporting requirements, and

establishing more robust privacy and security requirements including requiring adoption of cyber security best practices and specificity as to the collection and use of consumer information. We also proposed to adopt parallel standards for the use of QHP issuer Web sites under § 156.265(b)(2)(ii). See III.G.5.c of this preamble for a discussion of the amendments to § 156.265(b)(2)(ii).

We proposed to amend paragraph (g)(2)(ii) to clarify that HHS could determine an agent or broker to be noncompliant if HHS finds that the agent or broker violated any term or condition of the agreement with the FFEs required under paragraph (d) of this section, or any term or condition of an agreement with the FFEs required under § 155.260(b). We proposed to add § 155.220(g)(5) to address suspension or termination of an agent's or broker's agreements with the FFEs in cases involving potential fraud or abusive conduct. We proposed in § 155.220(g)(5)(i)(A) that if HHS reasonably suspected that an agent or broker may have engaged in fraud or abusive conduct using PII of an Exchange applicant or enrollee, or in connection with an Exchange enrollment or application, HHS could suspend the agent's or broker's agreement and accompanying registration with the FFEs for up to 90 calendar days, with the suspension effective as of the date of the notice to the agent or broker. We further proposed under § 155.220(g)(5)(i)(B) if the agent or broker failed to submit information during this 90-day period, HHS could terminate the required agreements for cause effective immediately upon expiration of the 90-day period, under § 155.220(g)(5)(ii). In § 155.220(g)(5)(ii), we proposed that if HHS reasonably confirmed the credibility of an allegation that an agent or broker engaged in fraud or abusive conduct using personally identifiable information of Exchange enrollees or applicants, or in connection with an Exchange enrollment or application, or was notified by a State or law enforcement authority of the State or law enforcement authority's finding or determination of fraud or behavior that would constitute abusive conduct in such a circumstance, HHS would notify the agent or broker and terminate, immediately and permanently, the agent's or broker's agreements with the FFEs. In § 155.220(g)(5)(iii), we proposed that during the 90-day suspension period, as well as following the termination of the FFE agreements, the agent or broker would not be registered with the FFEs, or be permitted to assist with or facilitate enrollment through the FFEs, or assist individuals in applying for Exchange financial assistance for QHPs. For consistency with these proposed termination standards, we proposed corresponding updates to paragraphs (g)(3) and (4), and proposed amending paragraph (f)(4) to remove the unnecessary reference to paragraph (g).

We proposed adding paragraph § 155.220(j) to establish standards of conduct for agents and brokers that assist consumers to enroll in coverage through the FFEs to protect consumers and ensure the proper administration of the FFEs. In § 155.220(j)(1)(i) through (iii), we proposed that an agent or broker that assisted with or facilitated enrollment of qualified individuals, qualified employers, or qualified employees through an FFE, or assisted individuals in applying for Exchange financial assistance for QHPs sold through the FFEs, would have to: (1) Execute the required agreement under § 155.260(b)(2); (2) register with the FFEs as described in paragraph (d)(1) of this section; and (3) comply with the FFE standards of conduct proposed in this paragraph. In § 155.220(j)(2), we proposed that the agents and brokers described in paragraph (j)(1) would have to: (1) Provide consumers with correct information, without omission of material fact, regarding the FFEs, QHPs (including SADPs [41]) offered through the FFEs and insurance affordability programs, and refrain from marketing or conduct that is misleading or coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation; (2) provide the FFEs with correct information under section 1411(b) of the Affordable Care Act; (3) obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment in coverage through an FFE, or prior to assisting with the application for financial assistance for QHPs sold through the FFEs; (4) protect consumer PII in accordance with § 155.260(b)(3) and the agreement described in § 155.260(b)(2); and (5) comply with all applicable Federal and State laws and regulations. In § 155.220(j)(3), we proposed that an agent or broker would be considered to be in compliance with the standard of conduct requirements to provide consumers and the FFEs with correct information if HHS determined that the agent or broker had a reasonable cause for any failure to provide correct information and that the agent or broker acted in good faith. We also proposed that the violation of these standards could result in the termination for cause of the agent's or broker's agreements with the FFEs as described in § 155.220(g), or the imposition of other penalties as authorized by law.

In § 155.220(k), we proposed penalties for agents and brokers registered with the FFEs other than termination of the agreements with the FFEs. In § 155.220(k)(1), we proposed that if HHS determined that an agent or broker failed to comply with the requirements of § 155.220 he or she could be denied the right to enter into an agreement with the FFEs in future years, and could be subject to CMPs as described in § 155.285 if the violation involved the provision of false or fraudulent information to an Exchange or the improper use or disclosure of information. In § 155.220(k)(2), we proposed that the denial of the right to enter into an agreement with the FFEs in future years would be subject to 30 calendar days' advance notice and the reconsideration process established in § 155.220(h). The imposition of CMPs for the provision of false or fraudulent information to an Exchange or the improper use or disclosure of information would be subject to the advance notice and appeals process described in § 155.285.

Finally, in § 155.220(l) we proposed that an agent or broker who enrolled qualified individuals, qualified employers, or qualified employees in coverage in a manner that constituted enrollment through an SBE–FP, or assisted individual market consumers with submission of applications for Exchange financial assistance through an SBE–FP would have to comply with all applicable FFE standards in § 155.220.

Comment: The proposal for the enhanced direct enrollment process received broad support by many commenters, who stated they believe enabling the applicant to remain on a web-broker's or issuer's non-Exchange Web site would improve the consumer experience by supporting more seamless transitions than the existing direct enrollment functionality. One commenter stated the proposal would increase enrollment, as the current direct enrollment functionality requires a consumer to be directed back and forth between the direct enrollment Web site and HealthCare.gov, leading some

[41] As detailed in the Exchange Establishment Rule (77 FR 18309, 18315) (Mar. 27, 2012), with some limited exceptions, SADPs are considered a type of QHP. We expect agents, brokers, and web-brokers registered with the FFEs to comply with applicable rules and requirements in connection with SADPs, just as they must comply with those rules in connection with medical QHPs.

consumers to drop out of the process before completing enrollment out of frustration over operational ineffeciencies or duplication. Commenters also broadly supported our proposal for the Exchange to continue being the entity responsible for making eligibility determinations and to continue to be the system of record for enrollment. Other commenters opposed the proposal, citing the increased risk of consumers receiving inaccurate or misleading information that might affect eligibility determinations and consumer choice. Some commenters urged HHS to take several considerations into account before moving forward with the proposal, including the potential negative impact on Medicaid-eligible populations.

FFE single streamlined application. We proposed to require web-brokers to use the single streamlined application without deviation from the language of the application questions and the sequence of information required for an eligibility determination. In support of the proposal, a few commenters stated that HHS should grant entities flexibility in the application process to enable integration into existing processes, and enable more innovation for a better consumer experience. Some commenters recommended that HHS instead use the FFE single streamlined application as a baseline, and allow web-brokers the opportunity to tailor applications for specific target populations. One commenter stated that consumers should only be required to answer questions that are relevant to their personal circumstances, so as to reduce consumer burden and application time. Another commenter stated that allowing minor changes to the wording of specific questions could help enhance the consumer experience, so long as the overall meaning of the question is maintained.

Other commenters called HHS's proposal to require web-brokers and issuers to strictly adhere to existing eligibility Exchange language a ''prudent safeguard,'' citing concerns that enhanced direct enrollment would increase the risk of consumers receiving inaccurate or misleading information that might affect eligibility determinations and consumer choice, and the potential for consumer confusion around communication with Exchanges.

HHS approval of alternative enrollment pathway processes. HHS solicited comments on requiring HHS approval of alternative enrollment processes in the proposed rule. Some commenters urged that HHS implement the approval process in a collaborative and flexible manner, with clear and concise guidelines. Other commenters strongly recommended that HHS confirm that all web-brokers adhere to certain criteria prior to offering enhanced direct enrollment services, including ensuring web-broker's application questions and flows provide accurate eligibility assessments and meet other requirements, such as providing appropriate consumer support, displaying all plan information fully and accurately, and demonstrating compliance with privacy and security standards via regular audits. One commenter asked HHS to adopt a ''check-list and review of required plan choice elements'' template that would enable HHS to validate the entities' plan choice displays, tools, and elements of their application. Another commenter encouraged HHS to minimally require web-brokers to submit a Minimum Acceptable Risk Standards for Exchanges ''(MARS–E) Compliance Manual'' as a pre-condition to offering the enhanced direct enrollment eligibility service, which would detail how they manage and comply with MARS–E compliance processes. One commenter stated that HHS should require web-based entities to seek prior approval for alternative direct enrollment processes by presenting their alternatives to HHS for review, before using any display features or tools that vary from those available on the Exchange Web site.

Timing. We received many comments on the timing related to implementation of the enhanced direct enrollment proposal. Some commenters wanted an aggressive implementation timeline, urging HHS to finalize and implement the FFE single streamline application process early in 2016 so that testing could occur well in advance of the 2017 Individual Market Open Enrollment period. Other commenters recommended HHS pursue a more measured approach, noting that developing, testing, and implementing the enhanced process will be a significant undertaking for HHS, web-brokers, and QHP issuers. One commenter stated that a measured approach would allow entities to use the Exchange approved web service for a transitional period alongside the traditional direct enrollment pathway. Another commenter urged that HHS wait several years before implementing the proposal, and gather and analyze data on the consumer experience with web-based entities during 2016, conduct an examination of its oversight of web-brokers and QHP issuers in 2017, and then propose any expansion with sufficient detail for implementation no earlier than 2018.

Response: Based on the comments received, we are finalizing the proposal to enhance the direct enrollment process with some modifications, as noted below.

We appreciate the many comments and recommendations on the direct enrollment proposal we received. While we believe that an enhanced direct enrollment process will provide a more seamless consumer experience, we agree with commenters that implementing the proposal will be a significant undertaking for HHS, web-brokers, and issuers, and that such an effort will require sufficient time for operational planning and preparation, such as identifying and testing the Exchange-approved web services under § 155.220(c)(1) that can be used to support the enhanced direct enrollment process, and ensuring privacy and security risks are addressed and mitigated. HHS will not provide such an option during the individual market open enrollment period for 2017 coverage, but seeks to make this option available for the individual market open enrollment period for 2018 coverage. We intend to supplement the framework we are finalizing in this rule with more specific guidance and requirements in future rulemaking, such as specific guidelines for a pre-approval process under § 155.220(c)(4)(i)(F), and requirements for privacy and security. Until then, web-brokers must continue to comply with the current direct enrollment process, through which a consumer is directed to HealthCare.gov to complete the eligibility application, and all associated guidance. This means direct enrollment entities are not permitted at this time to use non-Exchange Web sites to complete the Exchange eligibility application or automatically populate data collected from consumers into HealthCare.gov through any non-Exchange Web site. Completion of the Exchange eligibility application on a non-Exchange Web site, or collection of data through a non-Exchange Web site that is then used to complete the eligibility application, will be considered a violation of the direct enrollment entity's agreement with the FFEs.

While enhanced direct enrollment will not be available in the individual market open enrollment period for 2017 coverage, we are finalizing our proposal to revise § 155.220(c)(1) to enable web-broker entities who use HHS-approved direct enrollment processes to facilitate enrollment through the FFEs to either ensure the applicant's completion of an eligibility verification and enrollment

through the Exchange Internet Web site as described in § 155.405, or ensure that the eligibility application information is submitted for an eligibility determination through an Exchange-approved web service. This will allow applicants to complete the entire Exchange application and enrollment process on the web-broker's non-Exchange Web site. We believe this process will grant direct enrollment entities the operational flexibility to expand front-end, consumer-facing channels for enrollment, and provide consumers with a more seamless experience.

However, we also share commenters' concerns that allowing this flexibility without additional protections in place may increase the risk of imprecise, inaccurate, or misleading eligibility results. In light of those considerations and the accompanying comments received, we are adding new § 155.220(c)(3)(ii)(A) through (D) to clearly articulate the requirements associated with completing an Exchange eligibility application on a web-broker's non-Exchange Web site. These requirements may be amended over time as implementation activities begin and once experience is gained under the new process (once implemented).

Consistent with the proposal in the proposed rule, § 155.220(c)(3)(ii)(B) requires all language related to application questions, and the sequence the questions are presented on the direct enrollment entity's non-Exchange Web site to be identical to that of the FFE Single Streamlined Application. We acknowledge the comments requesting deviations from the FFE single streamlined application to enhance the consumer experience, and are finalizing language permitting such deviations with HHS approval. We will only approve minor modifications that do not change the intent or meaning of the questions, decrease the probability of accurate answers and eligibility determinations, or affect the dependencies and structure of the dynamic application.

We are also adding new § 155.220(c)(3)(ii)(C), which sets out a more general requirement that any non-Exchange Web site facilitating the completion of an Exchange eligibility application ensure that all information necessary for the completion of the application related to the consumer's applicable eligibility circumstance are submitted through an Exchange-approved web service. New § 155.220(c)(3)(ii)(D) requires that the process used for consumers to complete the eligibility application on the non-Exchange Web site comply with all applicable Exchange standards, including Exchange notice requirements under § 155.230 and Exchange privacy and security standards related to handling PII under § 155.260(b).

We have also renumbered the current requirements that apply when an Internet Web site of an agent or broker is used to complete the QHP selection process in new § 155.220(c)(3)(i). No changes were made to these existing requirements or the accompanying regulatory text. We note that, as outlined in § 155.220(c)(3)(ii)(A), these requirements would also apply when an Internet Web site of an agent or broker is used to complete the Exchange eligibility application.

We agree with commenters that urged HHS to adopt an approval process to ensure that the web-broker non-Exchange Web site seeking to offer stand-alone direct enrollment eligibility services meets all applicable requirements in order to protect consumers. Accordingly, we have added § 155.220(c)(4)(i)(F) to outline a process for HHS to verify that these entities have met all of the applicable requirements of this section before the non-Exchange Web site is used to complete the Exchange eligibility application.

The primary objective of the new requirements outlined in § 155.220(c)(3)(ii) and (c)(4)(i)(F) is to ensure that the Exchange is able to produce an accurate eligibility determination from an eligibility application completed by a direct enrollment entity on a non-Exchange Web site for enrollment in a QHP offered through the Exchange, including eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as enrollments in Medicaid, CHIP or the Basic Health Program. Alignment with the FFE Single Streamlined Application regarding sequence and language on a non-Exchange Web site to the FFE application is critical to ensuring that the information provided to the Exchange through the Exchange approved web-service represents a complete understanding of a consumer's circumstance, and is directly tied to ensuring accurate eligibility results. As noted above, HHS will consider allowing minor deviations from the standardized language, in order to improve readability or the consumer experience. We will provide guidance on the process for seeking approval to deviate from the standardized language.

We clarify that the requirements related to the direct enrollment process rules are applicable to FFEs (including FFEs where States perform plan management functions) and SBE–FPs only, and would not apply to SBEs that do not use the HealthCare.gov platform, nor alter any State-specific rules related to Medicaid eligibility.

Comment: HHS solicited feedback on experiences with enrollment through web-brokers, including any concerns with privacy and security of the information transmitted through web-brokers by expanding direct enrollment to incorporate the FFE single streamlined application and suggestions for improvements, including requiring additional information display requirements (such as the lowest cost plan at each metal level) beyond those outlined in § 155.220(c)(3) to ensure that consumers understand basic information about cost and availability of qualified health plans. We received several comments opposing HHS implementing additional consumer protection and privacy and security standards with respect to the use of the enhanced direct enrollment process. Some commenters stated that existing web-broker requirements are sufficient to ensure appropriate consumer protections. One commenter said issuers and web-brokers should not be required to display the lowest-cost plan in each metal level because existing decision support tools can filter plans based on customer input. However, one commenter suggested requiring conspicuous notice to consumers to ensure they are aware they are applying for Exchange coverage. Several commenters provided specific recommendations to ensure that consumers understand that they are applying for Exchange coverage, including creating standardized application ID numbers that enable consumers to create HealthCare.gov accounts that would link to their web-broker accounts. Several commenters did not support requiring branding on web-brokers' sites, since many web-brokers build platforms for their strategic partners with an expectation of maintaining brand continuity. Others supported specific branding requirements, recommending a consumer-tested ''seal of approval'' to demonstrate that the web-broker's application was approved by HHS. One commenter suggested that direct enrollment non-Exchange Web sites display a standard disclaimer that notifies consumers that eligibility determinations for Exchange coverage are made by the Exchange and not the web-broker or issuer, and directing that any questions, concerns, or appeals related to an eligibility determination be submitted to the Exchange.

Commenters generally agreed that web-brokers should continue to follow

existing privacy and security standards, including the Minimum Acceptable Risk Standards for Exchanges (MARS–E). Specific suggestions include requiring approval from CMS's Chief Information Security Officer, and the CMS Chief Technology Officer, providing CMS with a current MARS–E Compliance Manual and SSP System Security Plan (SSP) subject to verification via a pre-delegation audit by CMS, and appointing a designated, dedicated Privacy Officer responsible for attesting to the organization's adherence to privacy standards as outlined in the web-broker's agreement with HHS.

Other comments raised several concerns about the privacy and security of consumers' personally identifiable information, particularly citizenship and immigration status, and asked HHS to clarify how these entities would collect, store, and use PII. Some commenters wanted HHS to clarify that web-based entities will not gather and store data beyond that necessary for HealthCare.gov, State-based Exchanges, and Medicaid eligibility and enrollment via ''cookies'' or other tracking tools, and would not store or use information gathered from consumers in the application process for marketing other products.

Response: We agree that implementing the proposal will be a significant undertaking for HHS, and that privacy and security risks must be addressed prior to implementation. We intend for the standards outlined in this section to provide a framework to prepare for the implementation to support use of the enhanced direct enrollment option in future years. We will continue to consider commenters' recommendations on ensuring consumers are protected, and intend to propose further protections in future rulemaking.

Comment: HHS also solicited comments on about the current agent and broker provisions in § 155.220 as applied to web-brokers, including suggestions for improvements in the future, such as increased monitoring and oversight activities. Commenters supported HHS conducting regular audits over web-brokers. Additionally, some commenters supported ongoing monitoring of plan selection and enrollment patterns through comprehensive data analysis. Others stated that audits need to be conducted ''equitably,'' and that HHS should assist web-brokers in coming into compliance if violations are identified.

Response: We agree with commenters that supported HHS conducting regular audits of agents and brokers under this section to ensure ongoing compliance with applicable standards. We are adding § 155.220(c)(5), which authorizes HHS to periodically monitor and audit agents and brokers approved under this subpart. This audit authority would extend to agents or brokers who follow the current direct enrollment pathway that uses a non-Exchange Web site to complete QHP selection, as well as agents or brokers who follow the enhanced direct enrollment pathway that uses a non-Exchange Web site to complete the Exchange eligibility application.

Comment: One commenter stated that there was a drafting error in paragraph (f)(4). That paragraph relates to termination without cause, but the language in that paragraph uses the phrase ''for cause.''

Response: We confirm the drafting error—we are correcting the paragraph to read ''without cause.''

Comment: While many commenters supported the proposal for suspension and termination of an agent's or broker's agreements with the FFEs in cases of potential fraud or abusive conduct, several commenters opposed the proposal as an encroachment on, or preemption of, State law. These commenters asked that HHS refer instances of fraud and abuse to the State, encouraged the FFE to work closely with the State regulator to ensure consumers are protected, and urged HHS to allow the States to regulate agents licensed do business in their State ''without interference.'' Commenters also requested that HHS coordinate with issuers on issues of agent and broker fraud, and inform issuers when HHS has notified a State's department of insurance regarding specific fraud or misconduct issues.

Response: The proposal we are finalizing relating to agent or broker suspension or termination if HHS reasonably suspects fraud or abusive conduct pertains only to agents' and brokers' agreements and registration with the FFEs to assist consumers with enrollments through the FFEs; it does not otherwise interfere with any State authority to regulate agents or brokers who are licensed to business in their jurisdiction. While HHS may suspend or terminate the FFE agreements with an agent or broker, this suspension or termination would not impact State licensure of an agent or broker. As stated in the preamble to the proposed rule, the investigations and enforcement related to the conduct of agents and brokers with respect to enrollments through or interactions with the FFEs will be conducted in coordination with States. We are finalizing paragraph (g)(5)(ii) to clarify that HHS will limit terminations without 30-days advance notice to those situations where there is a finding or determination by a Federal or State entity that an agent or broker has engaged in fraud, or abusive conduct that may result in imminent or ongoing consumer harm. In response to comments received from the public on this matter, we are also adding paragraph (g)(6) to clarify that the State department of insurance or equivalent State producer licensing authority will be notified by HHS in cases of a suspension or termination of the agent's or broker's agreements and registration with an FFE effectuated under paragraph (g). HHS will also coordinate with affected QHP issuers if it will not impede any State or Federal law enforcement investigation and as permitted under applicable Federal or State law.

Comment: Several commenters were concerned that the proposal did not afford sufficient due process protections to agents and brokers, and pointed out that a 90-day suspension period could prevent a wrongly accused agent or broker from participating in most or all of an individual market open enrollment period for a given plan year. These commenters urged HHS to provide notice and opportunity to respond before implementing a suspension, as well as provide further guidance on what would define 'fraud' or 'abusive conduct.' Commenters proposed measures such as suspending or terminating based on clear, unequivocal, and convincing evidence, a threat of immediate consumer harm, and the opportunity for an appeal hearing before an administrative law judge. Some commenters suggested that a 90-day suspension period may not be sufficient to conduct a full investigation, and suggested a longer timeframe for suspension as well as a reference to § 155.1210 to emphasize the record retention obligation of an agent along with HHS's ability to access or audit agent and broker records.

Response: Section 1313(a)(5) of the Affordable Care Act provides the authority to implement any measure or procedure that the Secretary determines is appropriate to reduce fraud and abuse in the administration of the Exchanges. We believe that a 90-day suspension is not an unreasonable timeframe where there is suspected fraud or abuse by an agent or broker, who may sell plans through the FFE not only during open enrollment but throughout the year. We note that a similar requirement for Medicare providers, 42 CFR 405.371, gives HHS the authority to suspend payments for at least 180 days where

there is reliable information that an overpayment exists, or there is a credible allegation of fraud. HHS intends to use this suspension and termination authority to stop further FFE enrollment activity by the agent or broker in cases where the misconduct may cause imminent or ongoing consumer harm. Further, we are modifying paragraph (g)(5)(i)(B) to require HHS to review and make a determination whether to lift the suspension within 30 days of receipt of evidence to rebut the allegation of fraud or abusive conduct. This provides an opportunity to limit the length of the suspension with the timely submission of rebuttal evidence.

We are finalizing the proposed paragraphs (g)(5)(i)–(ii) so that suspension or termination will be effective starting on the date of the notice in cases of actions related to suspected fraud, or abusive conduct that may cause imminent or ongoing consumer harm; for other terminations for cause under paragraph (g)(1), agents and brokers will receive 30 days' notice with opportunity to respond prior to termination as currently described in paragraph (g)(3). We are finalizing proposed paragraph(g)(5)(i)(B) with modification, so that in cases where the agent or broker submits evidence during the suspension period, HHS will review it and make a determination whether to lift the suspension within 30 days of receipt of the evidence; if the rebuttal evidence fails to convince HHS to lift the suspension, or if the agent or broker fails to submit rebuttal evidence during the 90-day suspension period, HHS may terminate for cause the agent or broker's agreements with the FFEs under paragraph (g)(5)(ii).

We note that § 155.1210 applies to Exchanges and agents of Exchanges, but not agents of QHP issuers. However, agents and brokers are downstream entities of QHP issuers, and they should be bound by their agreement with the QHP issuer to provide access to records, under § 156.340(b)(4), and maintain records in accordance with the standard at § 156.705, and HHS may request those records as part of an investigation or audit.

Comment: Commenters generally agreed with the standards of conduct proposed in § 155.220(j) for agents and brokers as important consumer protections. One commenter suggested HHS go further in implementing standards for protecting PII, protected health information (PHI), and Federal tax information. Other commenters suggested that agents should be able to maintain flexibility to answer consumers' questions in a manner that is best understood by the consumers they serve, which may result in minor inaccuracies in the information provided to FFEs, and asked HHS to adopt a standard of good faith without the necessity of a finding of reasonable cause. Two commenters requested clarification of the requirement for consumer consent. Commenters also requested clarification on the prohibition on the use of the words ''exchange'' and ''marketplace'' in business names and Web sites since the words ''exchange'' and ''marketplace'' are common and have been part of the names of Web addresses of many long-standing insurance-related businesses that pre-date the Exchanges and are not intentionally misleading.

Response: In addition to the standards of conduct requirements in § 155.220(j), the FFE privacy and security agreement contains specific requirements for protecting PII, PHI, and Federal tax information. The requirement to provide accurate information to consumers is not intended to target generalities or minor imprecisions, but rather misrepresentations of material information that would affect a consumer's choice of coverage or subsidies. As described in preamble to the proposed rule,[42] we would interpret § 155.220(j)(2)(i), which requires agents, brokers and web-brokers to refrain from marketing or conduct that is misleading, to require that agents, brokers, and web-brokers avoid the use of the terms Marketplace or Exchange or other words in the name of a business or Web site if doing so could reasonably cause confusion with a Federal program or Web site. We intend to provide further information on the requirements for consumer consent under § 155.220(j)(2)(iii) in future guidance.

Comment: While several commenters approved of extending the FFE standards for agents and brokers to SBE–FP States, others wanted more flexibility for SBE–FP States to train, register, and provide oversight of agents and brokers. Commenters suggested allowing SBE–FPs to design and administer their own individual training and certification program with treatment of State-specific requirements and regulations that may not be adequately addressed by FFE training and registration. One commenter suggested that State-specific regulations and training materials should be made available for voluntary incorporation by the individual SBE–FP. Another commenter requested that all allegations of agent misconduct in SBE–FP States be referred to the State so State regulators can investigate the misconduct to see if additional consumer harm has occurred in off-Exchange sales.

Response: Because agents and brokers will be accessing the Federal platform to enroll consumers in SBE–FP QHPs, we are finalizing § 155.220(l), to require that they be registered with HHS (which includes training through HHS or an HHS-approved vendor as described in § 155.222 for agents and brokers serving individual market consumers), and that that they comply with all applicable FFE standards in § 155.220. As stated above, HHS will work closely with State departments of insurance (or equivalent State regulators of agents and brokers) in SBE–FP States in oversight of agents and brokers. The roles and responsibilities of HHS and the State will be specified through the Federal platform agreement. While HHS will consider future alternatives that would allow SBE–FPs to provide Exchange training, we note that States may require licensed agents and brokers to receive State-specific SBE–FP training as part of their continuing education to maintain a State license.

We are finalizing these provisions as proposed, with the following modifications. We are finalizing § 155.220(c)(1) to require agents or brokers to ensure an applicant's completion of an eligibility verification and enrollment application through an Exchange Internet Web site, or through an Exchange-approved Web service, subject to meeting the requirements under new paragraphs § 155.220(c)(3)(ii) and (c)(4)(i)(F). To ensure that the information provided to the Exchange through non-Exchange Web sites represents a complete and accurate determination of a consumer's eligibility for enrollment through the FFEs, we are adding § 155.220(c)(3)(ii)(B) to require all language related to application questions, and the sequence of questions presented on the agent or broker's non-Exchange Web site, to use the same language as the FFE single streamlined application in § 155.405. We are also adding § 155.220(c)(3)(ii)(C) to require all information for the consumer's applicable eligibility circumstances are submitted through an Exchange-approved Web service; and § 155.220(c)(3)(ii)(D) to require the process used for consumers to complete the eligibility application to comply with all applicable Exchange standards, including §§ 155.230 and 155.260(b). To ensure maximum consumer protection, we are also adding new § 155.220(c)(4)(i)(F) to outline a process for HHS to verify entities meet all requirements of this section prior to

[42] 80 FR 75526 (December 2, 2015).

using a non-Exchange Web site to complete the Exchange eligibility application. In addition, we are adding § 155.220(c)(5) to enable HHS to periodically monitor and audit entities to assess compliance with standards in this section. We are correcting an error in paragraph (f)(4) to change ''for cause'' to ''without cause.'' We are finalizing (g)(5)(i)(A) to add ''that may cause imminent or ongoing consumer harm'' after ''abusive conduct.'' To clarify the process for submitting evidence to rebut the allegation of fraud or abusive conduct, we are amending paragraph (g)(5)(i)(B) to add that if the agent or broker submits such evidence during the suspension period, HHS will review the evidence and make a determination whether to lift the suspension within 30 days after HHS's receipt of evidence. If the rebuttal evidence does not persuade HHS to lift the suspension, or if the agent or broker fails to submit rebuttal evidence during the suspension period, HHS may terminate the agent's or broker's agreements required under paragraph (d) of this section and under § 155.260(b) for cause under paragraph (g)(5)(ii) of this section. We are changing the language in paragraph (g)(5)(ii), relating to grounds for termination without notice. The proposed rule stated that if HHS reasonably confirms the credibility of an allegation that an agent or broker engaged in fraud or abusive conduct (or is notified by a State or law enforcement authority of the State or law enforcement authority's finding or determination of fraud or behavior that would constitute abusive conduct). Based on comments discussed above, we are revising this provision in order to clarify the grounds for termination without advance notice and the role of the State.

We are also eliminating a redundancy within the proposed rule. Paragraph (g)(5)(ii), as originally proposed, described the termination of the agent's or broker's agreement with the Exchange under § 155.260(b) as of the date of the notice. Consequently, to reduce duplication, we are deleting a similar sentence from (g)(5)(iii). We are adding paragraph (g)(6) so that the State department of insurance or equivalent State agent or broker licensing authority will be notified in cases of suspensions or terminations effectuated under paragraph (g).

Finally, we have made a small number of non-substantive changes to the rule to make language consistent as well as to clarify the date on which the 30-day window for reconsideration requests begins.

e. Standards for HHS-Approved Vendors of FFE Training for Agents and Brokers (§ 155.222)

In the proposed rule, we proposed changes to the standards for HHS-approved vendors of FFE training for agents and brokers outlined in § 155.222. To prevent duplication with HHS functions, we proposed eliminating the requirement that vendors perform information verification functions, including State licensure verification and identity proofing, as well as other changes to improve the vendor training model.

To reflect that HHS-approved vendors would no longer be required to perform information verification functions, we proposed amending § 155.222(a)(1) to provide that a vendor must be approved by HHS, and removing the reference to information verification. We also proposed in § 155.222(a)(2) to remove the requirement that vendors must require agents and brokers to provide proof of valid State licensure. Consistent with these changes, we proposed amending § 155.222(b)(1) through (5) and (d) to remove standards for information verification, identity proofing, verification of agents' and brokers' valid State licensure, and all related standards that support these functions. We proposed to eliminate the requirements in paragraphs (b)(1)(i) through (ii) to submit an application demonstrating prior experience with verification of State licensure and identity proofing, and instead combine into paragraph (b)(1) the existing requirements to demonstrate prior experience with online training and technical support for a large customer base. In paragraph (b)(2) we proposed to eliminate the requirement to adhere to HHS specifications for content, format, and delivery of information verification. In paragraph (b)(4) we proposed to amend the standards for the agreement that vendors must execute with HHS, to eliminate the requirement that vendors implement information verification processes. We proposed amending § 155.222(b)(5) and (d) to remove references to information verification.

Other proposed changes to this section incorporated the proposed standards for SBE–FPs, privacy and security measures, and technical support requirements. In paragraph (b)(2), we proposed to include SBE–FP States in the requirement to offer continuing education units (CEUs) in five FFE States. In paragraph (b)(3) we proposed to eliminate the requirement that vendors collect, store, and share with HHS all data from agent and broker users of the vendor's training; instead we proposed that vendors would only be required to collect, store and share with HHS FFE training completion data. We also proposed adding a paragraph (b)(6) to require vendors to provide technical support to agent and broker users of the vendor's FFE training as specified by HHS. In preamble, we noted that HHS has the authority to require approved vendors to provide technical support, as well as FFE training, in accordance with HHS guidelines and in a manner and format that complies with Section 508 of the Rehabilitation Act of 1973.[43] We also proposed that, the World Wide Web Consortium's Web Content Accessibility Guidelines (WCAG) 2.0 Level AA standards[44] could also be considered an acceptable national standard for Web site accessibility.

Comment: Commenters supported the proposed improvements to standards for vendors that wish to be approved by HHS to offer agent and broker FFE training. They supported the proposed change to § 155.222 that would eliminate the requirement that vendors conduct identity-proofing, as the current years' experience indicated that it was not needed and was duplicative of existing Exchange practices. They also supported the proposed requirement that vendors offer tier one help desk support for agent and broker users. One commenter requested that vendors be able to provide an additional level of help desk support (that is, tier two support) to brokers who were having trouble navigating the CMS Enterprise Portal. The commenter also suggested that scripted responses, reflecting vendor input, be provided to vendors at least two weeks prior to the FFE training launch. One commenter supported the provisions at § 155.222(b)(3) that require vendors to share only training completion data with HHS, as opposed to all data about users, and asked that HHS use that data to provide consumers with information about the availability of the assistance that agents and brokers provide.

Response: HHS will continue to work with approved vendors to enhance customer service and technical support to agents and brokers. Requirements for vendors' customer support and help desks will be included in guidance provided to conditionally approved vendors. All agents and brokers who successfully complete FFE training through an approved vendor or the CMS Marketplace Learning Management System (MLMS), in addition to other

[43] 80 FR 75487, 75528 (December 2, 2015).

[44] For more information see, the WCAG Web site at *http://www.w3.org/TR/WCAG20/*.

FFE registration steps, will be added to Find Local Help if they choose to make their contact information publicly available.

We are finalizing these provisions as proposed.

f. Standards Applicable to Certified Application Counselors (§ 155.225)

We proposed to amend § 155.225(b)(1) to provide that certified application counselor designated organizations must, as a condition of their designation as certified application counselor organizations by the Exchange, provide the Exchange with information and data related to the number and performance of the organization's certified application counselors, and about the consumer assistance being provided by the organization's certified application counselors, upon request, in the form and manner specified by the Exchange.

We explained that § 155.225(b)(1)(ii) already requires certified application counselor designated organizations to maintain a registration process and method to track the performance of certified application counselors, but it does not specify the type of performance information that must be tracked, nor does it require that information be provided to the Exchange. We stated that our proposed amendment would give Exchanges valuable information that will aid in their oversight of certified application counselor programs and improve Exchanges' understanding of the scope of consumer assistance being provided in the Exchange service area. The requirement would also improve the consumer assistance functions of the Exchange in other significant ways, for example, by providing information that could help an Exchange focus its outreach and education efforts, target its recruitment of certified application counselor organizations, and identify the need for increased technical assistance and support for certified application counselor organizations.

We explained that under this proposal, Exchanges could establish reporting standards tailored to their own specific needs and objectives. In States with FFEs, we proposed that HHS would collect information and data from certified application counselor designated organizations on a monthly basis beginning in January 2017. We proposed that the FFEs would require these organizations to report, at a minimum, data regarding the number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP. We anticipated that the monthly reports submitted to the FFEs would provide information and data from the preceding month, and would be submitted electronically, through HIOS or another electronic submission vehicle. We also said that we expected that some of the data that FFEs would require from certified application counselor designated organizations would be similar to what is collected from Navigator grantees in the FFEs.[45] We explained that we did not expect this information collection to include consumers' PII. We requested comments on our proposal, on the scope of information and data that Exchanges should collect, and on HHS's specific proposals for collecting information and data from certified application counselor organizations in the FFEs, including the proposed scope and timing of reports by these organizations to the FFEs.

We are finalizing this provision largely as proposed, with a modification to the frequency and timing of reporting required by FFEs, from a monthly basis beginning in January 2017, to a quarterly basis beginning with reports for the third quarter of calendar year 2017.

Comment: We received mixed comments related to our proposal to collect data from certified application counselor organizations. Many commenters supported the proposal, noting the value of tracking performance data. Many commenters also requested that we coordinate with the Health Resources and Services Administration (HRSA), which has reporting requirements related to their Affordable Care Act Health Center Outreach and Enrollment Assistance grants, in order to reduce duplication and administrative burden for Federally Qualified Health Centers that are both HRSA grantees and serving as FFE-designated certified application counselor organizations. We also received several specific suggestions for data elements to be collected by Exchanges, including metrics related to re-enrollment, assistance to consumers with limited English proficiency, and post-enrollment activities. One commenter requested that we develop a means for certified application counselor organizations to voluntarily report additional information that falls outside of the proposed performance measures.

Response: We agree that in general, tracking performance data will enhance the Exchanges' ability to oversee and support certified application counselor organizations, target outreach and education efforts, and identify training needs. In FFEs, we believe the information and data reporting we proposed aligns well with HRSA's Affordable Care Act Health Center Outreach and Enrollment Assistance grant reporting metrics. We also appreciate commenters' suggestions for additional FFE data elements to be reported. However, to minimize the burden on certified application counselor organizations, we are not adding to or changing the kind of information and data to be collected in FFEs.

Comment: A few commenters opposed this proposal, arguing that the requirements would be overly burdensome and could lead some certified application counselor organizations to discontinue their programs. Many commenters urged us to minimize the burden associated with certified application counselor performance data reporting. Commenters expressed concern that unfunded reporting burdens would further reduce the number of organizations able to provide critical enrollment assistance. Several commenters expressed concern regarding the scope and frequency of the proposed FFE reporting requirements, and recommended requiring less frequent reporting.

Response: We intend that any FFE information collection be straightforward, and place little burden on certified application counselor organizations, particularly given the resource constraints faced by many certified application counselor organizations. We recognize that certified application counselor organizations are not expected or required to be funded by Exchanges. In FFEs, to help minimize any burden on certified application counselors and certified application counselor organizations, while still providing FFEs enough information to meaningfully improve oversight of certified application counselor programs, we are finalizing a quarterly, rather than monthly, reporting schedule, beginning with reports for the third quarter of calendar year 2017, and are otherwise finalizing the provision as

[45] The data collection requirements for FFE Navigator grantees in 2015–2016 are specified in the Information Collection Request (OMB control number 0938–1215) under the Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges (see the Paperwork Reduction Act package associated with 80 FR 36810). *http://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201507-0938-001.*

proposed. Quarterly reporting submitted to the FFEs will be aligned with calendar year quarters (that is, Quarter 1: January 1–March 31; Quarter 2: April 1–June 30; Quarter 3: July 1–September 30; and Quarter 4: October 1–December 31). Quarterly reports submitted to the FFEs should provide information and data from the quarter and will be due 30 days after the end of the quarter. For example, the first report that will be due under this rule, the third quarter report for calendar year 2017, will cover the period from July 1, 2017 through September 30, 2017, and will be due October 30, 2017. This quarterly reporting period and deadline will generally align with both the FFE Navigator grant metrics and HRSA's Affordable Care Act Health Center Outreach and Enrollment Assistance grant reporting metrics. FFE Navigator quarterly reports are also due 30 days after the end of the quarter, and the quarterly reports under HRSA's grants are due approximately 10–15 days after the end of the quarter. We believe that quarterly reports will provide the FFEs with sufficient information to meaningfully improve oversight of certified application counselor programs.

We believe our final rule strikes the right balance between minimized burden and effective monitoring, and that it will improve the consumer assistance functions of the Exchange by providing Exchanges with information that could help focus their outreach and education efforts, target recruitment of certified application counselor organizations, and identify the need for increased technical assistance and support for certified application counselor organizations. We also remind SBEs (including SBE–FPs) that this provision gives them the option, but does not require them, to establish reporting standards and collect data from certified application counselor organizations, because the rule only requires organizations to provide data and information to the Exchange upon the Exchange's request.

Comment: We received many comments requesting additional guidance regarding performance metrics and the submission process for FFE reporting. Commenters requested clear guidance and instructions on defining the specific data elements to ensure that organizations can easily and consistently report data. In addition, commenters requested that the system for FFE reporting be easy to understand and access, and that HHS provide adequate training and support for the system. We received many comments suggesting that the FFE leverage existing IT and data collection platforms to avoid duplicative efforts. For example, commenters noted that certified application counselors working in FFEs provide their identification number and organization number on applications submitted through HealthCare.gov and that this number should be used to quantify the number of clients who received application assistance. Commenters also suggested that the FFEs track the number of certified application counselors through the FFE online training system.

Response: In FFEs, additional guidance on the reporting requirements will be published through instructions and trainings. We anticipate that quarterly reports submitted to FFEs would provide information and data from the preceding quarter, and would be submitted electronically, through HIOS or another electronic submission vehicle. We have considered commenters' suggestions related to alternative collection methods, but have significant concerns with the quality, completeness, and accuracy of data collected using these methods. The certified application counselor identification number field on applications submitted through HealthCare.gov is not a required field, and therefore is underreported. In addition, this number would not account for assistance certified application counselors provide to consumers who do not complete an application through HealthCare.gov. Tracking the number of certified application counselors in FFEs through our online training system only tracks who has completed the FFE training, not who has been formally certified. In FFEs, designated certified application counselor organizations, not FFEs, certify individual certified application counselors, and completion of the FFE training may be only one of several criteria prerequisite to certification. For example, certified application counselor organizations may require additional employee training, and some States have additional requirements that must be met before an individual can be certified as a certified application counselor. By collecting more accurate information, we believe FFEs will be better positioned to ensure adequate assistance is available to consumers.

Comment: A few commenters agreed that SBEs should have the option to establish their own reporting requirements to align with their needs. A few commenters requested that SBEs be allowed an exemption from this proposal if they determine that the administrative costs are too burdensome. One commenter requested that HHS establish limits on both the scope and frequency of performance data reporting requirements in all Exchanges. Commenters also noted that certified application counselor organizations that operate under the umbrella of national organizations would benefit from standardized reporting requirements across all Exchanges.

Response: In SBEs, including SBE–FPs, this provision only requires that organizations submit information and data to the SBE upon request, in the form and manner specified by the SBE, and therefore affords SBEs the flexibility to establish standards appropriate to their own specific needs and objectives. SBEs, including SBE–FPs, may weigh any increased administrative costs of requiring regular reports against the benefits of having additional information about the consumer assistance landscape in their State and decide whether, how, and when to collect data from certified application counselor organizations. In addition, we encourage SBEs to take into consideration the impact their reporting requirements will have on organizations that also serve as certified application counselor organizations in States with an FFE. We encourage SBEs to consider using, at a minimum, the data elements used by the FFEs, in order to minimize the burden on organizations that also serve as certified application counselor organizations in States with an FFE, but they are not required to do so if they do not believe that doing so fits their State's circumstances.

As discussed earlier in this preamble, in the discussion of the amendments to § 155.210(d)(6), we proposed to amend § 155.225(g)(4), which prohibits certified application counselors in all Exchanges from providing certain kinds of gifts and promotional items to an applicant or potential enrollee. For the same reasons discussed above, we proposed to amend § 155.225(g)(4) consistent with our proposed amendments to § 155.210(d)(6). Based on comments received, discussed above with the amendments to § 155.210(d)(6), we are finalizing this provision as proposed.

g. Privacy and Security of Personally Identifiable Information (§ 155.260)

Section 155.260(a)(1) refers to insurance affordability programs, as defined in § 155.20. We proposed to make a technical correction to this paragraph so that § 155.300, which contains the definition of insurance affordability programs, is referenced instead. We are finalizing this provision as proposed.

h. Oversight and Monitoring of Privacy and Security Requirements (§ 155.280)

Section 155.280(a) permits HHS to oversee and monitor the FFEs and non-Exchange entities associated with FFEs to ensure compliance with the privacy and security standards established and implemented by an FFE under § 155.260. Section 155.280(a) also provides authority for HHS to monitor State Exchanges for compliance with the privacy and security standards established and implemented by the State Exchanges under § 155.260. We proposed amending paragraph (a) to permit HHS to also oversee and monitor SBE–FPs' compliance with the privacy and security standards established and implemented by an FFE under § 155.260.

Comment: We received only a few comments on this proposal. A few commenters supported extending HHS's authority to oversee and monitor privacy and security standards to SBE–FPs, but expressed concern that since SBE–FPs conduct some operations themselves, HHS should be required to oversee and monitor SBE–FPs to ensure protection of consumer PII.

Response: We agree with the commenter that it is critical to ensure protection of consumer's PII, as well as ensure cybersecurity generally, across all Exchange models. We are committed to continue working with States to ensure compliance with all State and Federal requirements related to Exchanges, including Exchange privacy and security standards. We are finalizing the rule as proposed.

4. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. Options for Conducting Eligibility Determinations (§ 155.302)

We proposed to amend § 155.302(a) by adding an option for an SBE–FP to satisfy the requirement of conducting eligibility determinations by relying on HHS to carry out eligibility determination activity and other requirements within subpart D, through a Federal platform agreement. We did not receive any comments on this proposal, and are finalizing it as proposed.

b. Eligibility Process (§ 155.310(h))

We proposed to amend § 155.310(h), which currently directs the Exchange to notify an employer that an employee has been determined eligible for Exchange financial assistance. We proposed to revise this requirement so that the Exchange must notify an employer that an employee has been determined eligible for Exchange financial assistance only if the employee has also enrolled in a QHP through the Exchange. We also proposed to revise paragraph (h)(2) so that a notice sent in accordance with § 155.310(h) must indicate that an employee has been determined eligible for Exchange financial assistance and has enrolled in a QHP through the Exchange. We clarified that for purposes of § 155.310(h), an employee is determined eligible for cost-sharing reductions when the employee is determined eligible for cost-sharing reductions based on income in accordance with § 155.305(g) or § 155.350(a).

With regard to the timing of the employer notification required under paragraph (h), we proposed that the Exchange may choose to either (a) notify employers on an employee-by-employee basis as eligibility determinations are made for Exchange financial assistance and enrollment in a QHP through the Exchange, or (b) notify employers for groups of employees who are determined eligible for Exchange financial assistance and enroll in a QHP through the Exchange. Under both options, the Exchange must notify employers within a reasonable timeframe following any month an employee was determined eligible for either form of Exchange financial assistance and enrolled in a QHP, with the goal to notify employers as soon as possible to provide the greatest benefit to enrollees. We sought comment on these proposals.

Comment: Many commenters supported the requirement that an Exchange must notify an employer that an employee has been determined eligible for Exchange financial assistance only if the employee has also enrolled in a QHP through the Exchange. A few commenters stated that the proposed change would reduce consumer confusion and minimize administrative burden.

Response: We are finalizing § 155.310(h) as proposed.

Comment: Several commenters expressed concern that employer notices may contribute to employer retaliation and requested that HHS expressly prohibit employer retaliation and include such language on employer notices and elsewhere.

Response: Section 1558 of the Affordable Care Act amended the Fair Labor Standards Act of 1938 to provide that no employer may discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has received financial assistance under the Affordable Care Act. We intend to include language referencing section 1558 of the Affordable Care Act in notices from the FFEs under § 155.310(h) for 2016, and we encourage SBEs to do the same.

Comment: We received comments supporting both the policy that notices be sent in groups of employees and that notices be sent on an employee-by-employee basis. For example, one commenter expressed concern that notifying employers in groups of employees could delay the notification process. Another commenter supported the proposal that the Exchange may choose the manner and timing by which to send notices.

Response: To allow for operational flexibility and the varying needs of different Exchanges, we are finalizing the proposed language allowing an Exchange to choose to send notices on an employee-by-employee basis or in groups of employees. We note, however, that for 2016, the FFEs intend to send notices in groups of employees.

Comment: A few commenters requested that we further define the requirement to notify employers within a reasonable timeframe following any month an employee was determined eligible for Exchange financial assistance and enrolled in a QHP through the Exchange. They stated that that failure to send notices within one month could result in adverse tax consequences for the employee.

Response: While we understand the concerns that the commenters expressed, we are finalizing this provision as proposed in order to provide the Exchange with flexibility to make decisions based on its operational capabilities. As we stated in the proposed rule, the Exchange must notify employers within a reasonable timeframe following any month an employee was determined eligible for either form of Exchange financial assistance and enrolled in a QHP through the Exchange, *with the goal to notify employers as soon as possible to provide the greatest benefit to enrollees* (Emphasis added). The goal of the Exchange must be to send notices as soon as possible. We remind stakeholders that tax liability is determined by the IRS, and is not affected by these notices or the employer appeals process.

Based on the comments received, we are finalizing paragraph (h) as proposed. The FFEs intend to publish a sample notice that complies with § 155.310(h)

for the benefit of employers, employees, SBEs, and other stakeholders.

c. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

In § 155.320(c), we proposed to allow an Exchange to establish a reasonable threshold at which the Exchange must follow the alternate verification process where the applicant's attested projected annual household income is sufficiently below the annual income computed in accordance with § 155.320(c)(3)(ii)(A). Currently, an applicant enters the alternate verification process if the attested annual household income submitted by the applicant is more than 10 percent less than income data received from trusted data sources, or if no data is available from trusted data sources. Under the proposal, in place of the 10 percent threshold, the Exchange would establish a reasonable threshold in guidance that must be approved by HHS, must not be less than 10 percent, and can also include a threshold dollar amount.

We are finalizing this rule as proposed.

Comment: Commenters overwhelmingly supported adjusting the threshold in § 155.320(c). Commenters stated that the current 10 percent threshold is too restrictive and causes too many applicants to enter the alternate verification process. Commenters stated that the alternate verification process is burdensome to applicants because providing proof of projected income can be difficult. Some commenters suggested that a reasonable threshold should not be less than 20 percent or 25 percent. Other commenters recommended that HHS also do more to assist applicants in the resolution of annual income data matching issues.

Response: HHS will continue to study what threshold may be most appropriate, taking into account normal fluctuations in applicants' annual household income and experience with the tax reconciliation process. HHS will release guidance for Exchanges on what constitutes a reasonable threshold and to clarify the process for an Exchange to receive approval from HHS. HHS believes that clear outreach and notice for applicants related to the annual household income attestation process is critical. To that end, HHS released a new guide for applicants with annual household income data matching issues. The guide is available at the HHS Web site: *https://marketplace.HHS.gov/outreach-and-education/household-income-data-matching-issues.pdf.*

Comment: One commenter recommended against adjusting the threshold because it would result in adverse tax consequences for applicants. Instead, the commenter suggested that HHS should broaden the time period it uses when checking income from trusted data sources during the verification process like Equifax Workforce Solutions from 90 to 360 days.

Response: HHS may examine the proposal for expanding data used as part of the electronic data service for upfront verification of income as part of consumers' initial application submission.

Comment: One commenter suggested that an Exchange use the same standard for entering the alternate verification process as the Exchange uses to resolve applicants with annual household income data matching issues.

Response: The two processes are different since they are comparing different data elements. The purpose of the alternate verification process is to examine the difference in an applicant's attested projected annual household income and information from trusted data sources, whereas the resolution of data matching issues depends on an examination of whether an applicant's submitted documentation is satisfactory evidence to support their attested projected annual household income.

Comment: One commenter suggested that applicants be allowed to provide an explanation for discrepancies in their income, and that a standardized form should be provided for applicants to attest to their income as a means of verifying their income in the alternate verification process.

Response: HHS believes the use of written explanations that include sufficient information to calculate an annual income are a valuable tool for applicants, and has implemented procedures for handling explanations of income that accompany documentation of income.

Comment: The majority of commenters expressed support for granting the Exchanges flexibility in setting a reasonable threshold to meet varying Exchange needs, including related to State demographics. One commenter stated that all Exchanges should use the same threshold for applicants entering the alternate verification process.

Response: HHS supports granting Exchanges flexibility to establish a reasonable threshold, but all thresholds are subject to the same reasonability standard.

Comment: One commenter suggested that as a strategy to help applicants avoid repayment of advance payments of the premium tax credit (APTC) at tax time, Exchanges should set the default applied APTC amount at 85 percent. The commenter stated that this would allow for some flexibility for income changes during the year, and protect applicants against repayment during tax reconciliation.

Response: HHS believes that it is important to educate applicants about how changes in their income affect their eligibility for the premium tax credit. During plan selection, applicants are notified that they can accept the full amount of advance payments of the premium tax credit for which they have been determined eligible, accept a smaller amount, or accept no advance payments and claim any premium tax credit they are eligible for on their tax returns. Applicants are also notified that they may have to pay money back through the tax reconciliation process if the APTC they receive exceeds the PTC they can claim on their tax return.

Comment: One commenter suggested allowing for additional flexibility in verification for annual household income for certain occupations that have greater variability in their income such as self-employed merchants, artists, and small business owners.

Response: HHS understands that projecting annual household income can be difficult, particularly for applicants who have occupations that have high variability in income. HHS has worked to improve the resolution of annual household income data matching issues for these applicants by performing outreach and creating educational materials with instructions for verifying variable income.

In § 155.320(d), we made certain proposals related to alternative processes relating to verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. In paragraph (d)(3), we proposed to redesignate paragraph (d)(3)(i) as (d)(3)(ii) and redesignate paragraph (d)(3)(ii) as (d)(3)(i). To preserve the accuracy of the redesignated paragraph (d)(3)(ii), we proposed to update the cross-reference to paragraph (d)(3)(ii) with (d)(3)(i), and paragraph (d)(3)(iii) with (d)(4)(i), discussed below. We also proposed to modify the requirement that the Exchange select a statistically significant random sample of applicants for whom the Exchange does not have data as specified in paragraphs (d)(2)(i) through (iii) and take steps to contact any employer identified on the application for the applicant and the members of his or her household to

verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. This process is referred to as sampling. We proposed to modify this requirement as described in our in our discussion of proposed paragraph (d)(4) of the proposed rule. These proposed changes were intended to organize and simplify the regulatory text.

We proposed to add paragraph (d)(4), proposing that for any benefit year for which an Exchange does not reasonably expect to obtain sufficient verification data, the Exchange must follow the procedures described in paragraph (d)(4)(i) or, in the alternative, for benefit years 2016 and 2017, the Exchange may establish an alternative process approved by HHS. For the purposes of this section, the Exchange reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, the Exchange is able to obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to the Exchange and has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden.

In paragraph (d)(4)(i), we proposed that the Exchange may conduct sampling. This paragraph is substantially the same as current paragraph (d)(3)(iii), with three differences described in the proposed rule: we proposed to (1) remove the absolute requirement to conduct sampling, and, for benefit years 2016 and 2017, allow the Exchange to implement an alternative process approved by HHS; (2) remove the language that appears in current paragraph (d)(3)(iv), which discusses relief that is no longer applicable; and (3) appropriately update internal cross-references. We proposed moving the sampling requirement from paragraph (d)(3) and adding it to new paragraph (d)(4) to more accurately reflect the role of the sampling process. In paragraph (d)(4)(ii), we proposed to permit an Exchange the option to implement an alternate process to sampling approved by HHS for the benefit years 2016 and 2017.

Comment: Commenters generally supported the proposal to permit an Exchange to implement an alternate process to sampling approved by HHS for the benefit years 2016 and 2017. A few SBEs opposed the sunset for the alternate process to sampling.

Response: We understand that certain SBEs may prefer the flexibility to implement either sampling or an alternate process indefinitely. However, the alternate process should be used as an interim measure to gather information about the verification process as Exchanges improve their long-term verification programs. We will take these comments under advisement for future rulemaking.

Comment: We also received several comments pertaining more broadly to verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.

Response: We agree with commenters on both the benefits of a comprehensive verification system for employer sponsored coverage, and on the considerable operational challenges of creating one.

We are finalizing the changes to § 155.320(d) as proposed.

d. Medicare Notices

We recognize the importance of a smooth transition to Medicare coverage, and sought comment on whether and how to implement a notification that an enrollee may have become eligible for Medicare. For example, for enrollees in an FFE, we considered pop up text on HealthCare.gov for individuals who are going to turn 65 during the benefit year. We sought comment on this and other ways to promote smooth coverage transitions.

Comment: All commenters supported implementation of the pop-up text on HealthCare.gov for individuals who are going to turn 65 during the benefit year. Most commenters also expressed a desire for more robust notice and screening requirements. Several commenters requested that the FFE implement a screening process to identify QHP enrollees who are Medicare-eligible or who will be reaching Medicare eligibility during the benefit year. Several commenters suggested that the FFE provide additional education to QHP enrollees nearing Medicare eligibility, including information related to Medicare enrollment, penalties for not timely enrolling in Medicare, the requirement to return to the FFE in order to terminate financial assistance for which Medicare beneficiaries no longer are eligible or to terminate their QHP enrollments, and options for those automatically enrolled into a Medicare Advantage plan. Most commenters also requested that the option of a pop-up screen on HealthCare.gov be augmented by notices sent to QHP enrollees nearing eligibility to enroll in Medicare (including those QHP enrollees whose eligibility to enroll in Medicare is due to disability or end stage renal disease). Commenters had varied suggestions related to the form and content of the notices, but most suggested notices containing information related to deadlines for Medicare enrollment and penalties for late enrollment, instructions on how to terminate enrollment in a QHP or to remove a Medicare beneficiary from an enrollment group prior to enrolling in Medicare, and instructions on how to terminate financial assistance, such as APTC, for which Medicare beneficiaries are no longer eligible. Some commenters had specific suggestions related to identifying and notifying QHP enrollees who are eligible for Medicare benefits due to disability or end stage renal disease. Finally, some commenters requested information related to how State-based Exchanges would be affected by new Medicare notice requirements.

Response: We appreciate the comments related to this issue. We are working to incorporate additional online content to help clarify for consumers who may be close to aging into Medicare, or who may already be eligible for Medicare or receiving Medicare benefits, to provide better clarity around how Medicare and Exchange coverage are intended to work, and options consumers may have as they transition into Medicare coverage from Exchange coverage. In addition, we are working on enhancing consumer communications on how to transition from Exchange coverage to Medicare, and helping consumers understand where to find helpful resources for both programs. We welcome further input and assistance as we work towards implementing a framework to ease QHP enrollees' transition from coverage through the Exchanges to Medicare enrollment.

5. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

a. Annual Eligibility Redetermination (§ 155.335(j))

In the Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges final rule (79 FR 52994, 53000 (Sept. 5, 2014)), we established a renewal and re-enrollment hierarchy at § 155.335(j) to minimize potential enrollment

disruptions. To further minimize potential disruptions of enrollee eligibility for cost-sharing reductions, we proposed to amend § 155.335(j)(1) to create a new re-enrollment hierarchy for all enrollees in a silver-level QHP that is no longer available for re-enrollment. Specifically, if such an enrollee's current silver-level QHP is not available and the enrollee's current product no longer includes a silver-level QHP available through the Exchange, we proposed that the enrollee's coverage would be renewed in a silver-level QHP in the product offered by the same issuer that is the most similar to the enrollee's current product, rather than in a plan one metal level higher or lower than his or her current silver-level QHP, but within the same product. Transitioning enrollees in this manner is an operationally efficient way to maintain continuity for enrollees eligible for cost-sharing reductions, and, because the benchmark plans for establishing the amount of the premium tax credit for which an eligible taxpayer is eligible is a silver-level plan, continued enrollment in a silver-level plan, as opposed to enrollment in a plan at a different metal level but in the same product is likely to be more consumer protective.

We also sought comment on whether the hierarchy, together with rules related to guaranteed renewability, should permit a QHP enrollee to be automatically re-enrolled into a plan not available through an Exchange, and under what circumstances such a re-enrollment should occur.

As in the 2016 Payment Notice proposed rule, we also noted that we are exploring a change to the re-enrollment hierarchy at § 155.335(j), which currently prioritizes re-enrollment with the same issuer in the same or a similar plan.

In the proposed rule, we stated we were considering an approach under which an enrollee in an FFE would be offered a choice of re-enrollment hierarchies at the time of initial enrollment, and could opt into being re-enrolled by default for the subsequent year into a low-cost plan, rather than his or her current plan or the plan specified in the current re-enrollment hierarchy.

Comment: Many commenters supported our proposal with respect to silver-level QHPs, agreeing that it assists enrollees in those plans in maintaining access to cost-sharing reductions. These commenters stressed that access to that financial assistance can be of vital importance to many enrollees. Several commenters expressed concern that automatically re-enrolling a silver-level plan enrollee into a different product might affect the enrollee's provider network, benefits, and continuity of care, or stand-alone dental coverage. Some commenters stated that education and proper notices could help ensure that enrollees actively re-enroll in coverage if they are automatically re-enrolled in a plan that does not fit their needs. Several commenters stressed that issuers, who have the experience and information necessary to ensure enrollees are matched with a product that most closely fits their needs while minimizing potential disruptions in coverage and cost-sharing reductions, are in the best position to determine which available plans are the most similar to plans that are no longer available.

Response: We are sympathetic to the comments stating that enrollees should return to the FFEs to actively re-enroll in the coverage that best fits their needs. We recognize, however, that automatic re-enrollment hierarchies must exist to help those who do not take advantage of the opportunity actively to choose coverage for the benefit year. Therefore, while we acknowledge that re-enrollment between products can result in disruption to provider networks, benefits, and continuity of care, we believe it is important to maintain enrollees' access to cost-sharing reductions in silver plans, which might be vital to their ability to pay for coverage or care. We are finalizing this provision of the rule as proposed, except that for the purpose of clarity we are finalizing a slight modified version of the language in paragraph (j)(1).

Comment: We received many comments regarding the proposed alternative re-enrollment hierarchy, many of them mirroring comments made to our proposal in the 2016 Payment Notice. Commenters who opposed permitting an alternative low-cost enrollment hierarchy stated that, in most cases, the plan a consumer chooses during open enrollment is one that the consumer has shopped for and has determined best meets his or her needs. Additionally, commenters said that low-cost premiums do not necessarily lead to lower overall cost of coverage because deductibles, copayments, coinsurance, and out-of pocket limits may be higher in QHPs with low premiums. A minority of commenters supported the proposal's emphasis on low premiums.

Response: We appreciate the many comments received regarding alternative re-enrollment hierarchies and are sensitive to the concerns raised by commenters. We recognize that consumers consider many factors in addition to premium when selecting health coverage, including the provider network, cost-sharing, deductibles, and other factors that affect overall costs, continuity of care, and the consumer experience. We are not finalizing this proposed additional re-enrollment hierarchy.

Comment: Many commenters responded unfavorably to the suggestion that enrollees in QHPs could be automatically re-enrolled into off-Exchange plans because they would lose any advance payments of the premium tax credit or cost-sharing reductions they had been receiving. Several stressed that such a plan would cause consumer confusion.

Response: In response to these comments, and in order in to maintain coverage with advance payments of the premium tax credit and cost-sharing reductions for the majority of Exchange enrollees who are receiving them, we are finalizing a rule that would provide for auto-reenrollment through the Exchange, as opposed to permitting auto-reenrollment outside the Exchange. Under this rule, an enrollee could automatically be re-enrolled into a QHP from a different issuer through the Exchange. Such reenrollments would be conducted as directed by the applicable State regulatory authority, or, where the applicable State's regulatory authority declines to act, to the extent permitted by applicable State law, in a similar QHP as determined by the Exchange. With regard to how Exchanges will determine which plans such enrollees should be auto-reenrolled into, we note that this policy provides considerable flexibility to Exchanges to implement this rule, in recognition of the operational realities of implementing a re-enrollment hierarchy in the often unique circumstances in which an issuer is not returning to the Exchange. However, whenever feasible, the Exchange should, and the FFE will attempt to, re-enroll enrollees in silver metal-level QHPs no longer available through the Exchange into the silver metal-level QHP offered by another issuer through the Exchanges of the same product network type with the lowest premium. If the QHPs that have become unavailable are in metal levels other than silver, then whenever feasible, the Exchange should and the FFE will seek to re-enroll the affected enrollees in the QHP available on the Exchange of the same metal level of the same product network type with the lowest premium. Exchanges should, and the FFEs will endeavor to, implement such a re-enrollment process for enrollees of QHPs whose issuers are discontinuing their coverage, for as many groups as is feasible given the short timelines and complex operations

that could be required in these scenarios. Those groups for which such reenrollment is not feasible will need to make an active plan selection to remain enrolled in a QHP through the Exchange. We note that such a re-enrollment generally would require a binder payment from a consumer in order to be effectuated. In future guidance, we intend to update the Federal standard notices that address how issuers that no longer have plans available through the Exchange should communicate with consumers. We anticipate providing that an issuer that no longer has plans available through the Exchange may notify its enrollees of that fact, and may encourage them to enroll in the issuer's off-Exchange plans, but may not automatically enroll them in those plans, to avoid automatic enrollment in more than one plan. We intend to provide additional guidance on the application of the rules related to guaranteed renewability to this type of situation in the future.

Comment: We received a few comments requesting more information regarding how the proposed alternative re-enrollment hierarchy would affect stand-alone dental plans. Some commenters stated that the process for re-enrolling in a SADP should be independent from re-enrollment in a QHP.

Response: Because we will not implement the proposed alternative reenrollment hierarchy at this time and the policy for consumers whose issuer exited the Exchange would not apply to SADPs, we are not addressing how this policy would affect SADPs. However, we appreciate the comments raising this issue and, if the proposal is revisited in the future, we will address concerns regarding SADPs then.

b. Enrollment of Qualified Individuals Into QHPs (§ 155.400)

(1) Rules for First Month's Premium Payments for Individuals Enrolling With Regular, Special, and Retroactive Coverage Effective Dates

We proposed to amend § 155.400(e) related to the payment of the first month's premium (that is, binder payments), including deadlines, to codify previously released guidance in section 8.2 of the updated Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual,[46] that specified our interpretation of these requirements. Specifically, we proposed to amend § 155.400(e)(1)(i) and (ii) to provide that, for prospective coverage, the binder payment must consist of the first month's premium. To provide added flexibility for issuers, we also proposed that the deadline for a binder payment related to prospective coverage with a prospective special effective date, would have to be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later. This would align the requirement for enrollments with prospective special effective dates with the requirement for enrollments with regular effective dates. We proposed to add § 155.400(e)(1)(iii) to reflect our interpretation, intended to limit the risk that issuers would provide retroactive coverage without receiving sufficient premium payments from enrollees, that applicants requesting coverage being effectuated under retroactive effective dates, such as coverage in accordance with a special enrollment period or a successful eligibility appeal, must pay a binder payment that consists of all premium due (meaning the premium for all months of retroactive coverage). If the applicant pays only the premium for one month of coverage, we proposed that the issuer would be required to enroll the applicant in prospective coverage in accordance with regular effective dates. We also proposed to specify that the deadline for payment of all premium due must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction or notification of the enrollment. This change to the binder payment rules was intended to allow issuers flexibility to set a reasonable deadline for enrollees to submit payment of retroactive premium, the total amount of which may consist of payment for several months of coverage.

Based on our experience implementing the grace period provisions under our previous rulemaking, particularly in cases involving advance payments of the premium tax credit, we identified the need for additional flexibility for issuers to establish reasonable policies regarding premium collection that would allow issuers to collect a minimal amount of premium less than that which is owed without necessarily triggering the consequences for non-payment of premiums. For example, in the Exchange Establishment Rule, we established that enrollees receiving advance payments of the premium tax credit must make full payment on all outstanding premiums owed in order to avoid entering a grace period or having their coverage terminated. In response to requests from issuers, we proposed to add flexibility to this rule to allow issuers the option to adopt a premium payment threshold policy to avoid situations in which an enrollee who owes only a *de minimis* amount of premium has his or her enrollment terminated for non-payment of premiums.

Accordingly, at new § 155.400(g), we proposed to codify a provision related to premium payment threshold policies that would allow additional issuer flexibility regarding when amounts collected will be considered to satisfy the obligation to pay amounts due, so long as issuers implement such a policy uniformly and without regard to health status, and the premium payment threshold adopted is reasonable. This would allow issuers flexibility to effectuate an enrollment, not to place an enrollee in a grace period for failure to pay 100 percent of the amount due, and not to terminate enrollments after exhaustion of the applicable grace period for enrollees. We are finalizing these policies as proposed.

Comment: We received several comments regarding the proposal to set deadlines for payment of the first month's premium (binder payments). Some commenters appreciated the flexibility that such a proposal gives to issuers to set such deadlines while others commented that the proposal would resolve ambiguity revolving around the binder payment deadlines for special and retroactive effective dates. Several commented that the guidelines would provide consumer protection by not allowing payment due dates before the effective date of coverage. One commenter suggested that the final rule allow issuers flexibility to offer consumers coverage effective dates that would be more generous than those contained in the proposal and another commenter stated that issuers should be permitted to set a binder payment deadline no later than the coverage effective date.

Response: The final rule allows issuers flexibility to set binder payment deadlines within a set of parameters we believe balances concerns about consumer protection and issuers' desire to have flexibility regarding business decisions. While we are sympathetic to the desire to give consumers a generous amount of time to pay binder payments, we believe that the final rule allows issuers to set payment deadlines in such a way that consumers have ample time

[46] Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual (eff. Oct. 1, 2015), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated_ENR_Manual.pdf.*

to effectuate coverage. We also note that the final rule allows issuers to set the binder payment deadline on the coverage effective date, but not on a date earlier than the coverage effective date.

Comment: Some commenters were confused about the additional language to allow first month's premium payments after the coverage effective date, thinking that a person's coverage could be effectuated prior to the person making their payment. These commenters opposed allowing more individuals to appear to have effective coverage and then have the coverage not be effectuated due to non-payment of premium by the payment deadline.

Response: As we previously have stated, payment for first month's premium is required prior to coverage being effectuated. For the FFE, in cases where an enrollee, consistent with an issuer's payment policy, makes his or her premium payment after the coverage effective date, but before the premium payment deadline set by the issuer, the enrollee would receive a retroactive effective date. Issuers may pend claims while waiting for the first month's premium payment and either deny or reverse those claims based on whether the enrollee makes the first month's payment by the premium payment deadline. We believe that it is appropriate to allow payments, if the issuer chooses, after the coverage effective date.

Comment: One commenter recommended a modification to § 155.400(e)(1)(iii) to give consumers requesting retroactive coverage effective dates more flexibility. The commenter felt that requiring a binder payment consisting of all premium due would be a hardship to lower-income enrollees and, in order to avoid such hardship, issuers should be required to accept payment plans when consumers enroll with a retroactive effective date.

Response: While we understand it might be difficult for some consumers to pay all premium due to effectuate with a retroactive effective date, we believe that such a policy is necessary to minimize the risk that providers and issuers would honor claims during, potentially, several months of retroactive coverage without receiving corresponding premium payments from consumers. The proposed rule allows consumers who might have difficulty paying for retroactive coverage to enroll with prospective coverage only. It is our interpretation of § 155.400(e)(1)(iii) that a binder payment for retroactive coverage consists of all premium due, or a payment sufficient to satisfy the issuer's premium payment threshold, if applicable.

Comment: One commenter expressed concern about the proposed binder payment rules for coverage with retroactive effective dates, noting that if an issuer receives only the premium for one month of coverage, the enrollees would effectuate for prospective coverage with a regular effective date. The commenter thought this proposal to be inconsistent with the FFE's current guidance related to altering coverage effective dates without instruction to do so from the FFE, which generally, but not always, requires a transaction from the FFE in order to set or alter enrollees' coverage effective dates.

Response: Although issuers generally should not grant or alter coverage effective dates without a transaction from the FFE, there are cases where FFE guidance is sufficient to give rise to such an alteration. For example, current FFE guidance allows issuers to cancel coverage, without any directive from the FFE, for enrollees who have not paid their binder payments by the applicable due date. We believe that allowing enrollees who make a binder payment insufficient to satisfy all premium due but sufficient to effectuate prospective coverage to effectuate prospectively with a regular effective date protects consumers and promotes the goal of getting consumers into coverage while not conflicting with current regulations or FFE policies.

Comment: Several organizations commented on the proposal to codify the provision related to premium payment threshold policies which allows additional issuer flexibility regarding when amounts collected will be considered to satisfy the obligation to pay amounts due, so long as issuers implement such a policy uniformly and without regard to health status and that the premium payment threshold adopted is reasonable. Most commenters saw the proposal as providing important consumer protections and allowing sufficient flexibility for issuers to tailor the threshold as they wished, within the parameters set by HHS. A few of the commenters, however, claimed that the proposed rule would cause providers to bear the burden of claims, subsequently reversed by issuers, incurred during the second and third months of a grace period for enrollees receiving APTC.

Response: We do not believe that codifying the premium payment threshold will lead to additional uncompensated claims. The purpose of the threshold, which issuers may utilize at their option, is to keep enrollees from entering a grace period or having their enrollments terminated for non-payment of premium when the amount they owe is within a reasonable threshold. Issuers' adoption of the premium payment threshold could serve as a method to avoid terminating enrollments for non-payment of premium for enrollees who only owe a small amount of premium. We do not believe this policy will have the effect of increasing the number of consumers who enter the grace period or who are terminated from coverage for non-payment, the predicate for pended claims that are not eventually paid.

Comment: One commenter sought clarification that, under the premium payment threshold policy proposed in the rule, unpaid premium within a reasonable threshold tolerance, is still an amount owed by the enrollee and cannot be forgiven by the issuer.

Response: Any amount that is unpaid but within the tolerance of a reasonable premium payment threshold established by an issuer remains an amount owed by the enrollee and cannot be forgiven by the issuer. This remains true whether the premium payment threshold is utilized for any of the following payments: binder payments, regularly-billed payments, or amounts owed by an enrollee while in a grace period.

Comment: Two commenters requested that, due to that the complexity of creating the necessary operations framework to institute the premium payment threshold policy, the regulation should not be effective until 2017 or 2018. One commenter requested that the final rule provide for implementation of a threshold based, at an issuer's discretion, on a flat dollar amount or a percentage of the total member responsible portion of premium owed.

Finally, one commenter requested that we amend the proposed rule to make the premium payment threshold mandatory for all issuers. Additionally, the commenter sought a change to the proposed rule setting a 90 percent percentage of member responsible portion of premium as the mandatory threshold for all issuers.

Response: The proposed rule included flexibility for issuers to implement a premium payment threshold to suit their specific business, provided the threshold adopted is reasonable. We did not consider utilizing a flat dollar amount threshold rather than a percentage of premium owed to be reasonable, because such an approach would not take into account the possibility that even a low flat dollar amount may represent a large portion of an enrollee's portion of premium after application of APTC. We previously have recommended a premium payment

threshold of 95 percent,[47] which we consider to be reasonable. Although we understand the desire to provide uniformity of consumer protections across the FFEs, we do not wish to make the premium payment threshold a mandatory policy nor to set a mandatory threshold at a fixed percentage, as specific facts may justify a higher or lower one. Finally, because the premium payment threshold policy is implemented at the option of each issuer, we do not believe there is a reason to delay implementation of the regulation due to operational complexity.

(2) Reliance on HHS to Carry Out Enrollment and Related Functions

We also proposed to amend § 155.400 by adding a new paragraph (h) to reflect that SBE–FPs must agree to rely on HHS to implement the functions related to eligibility and enrollment within subpart E, through the Federal platform agreement. This reflects that eligibility and enrollment functions must be performed together in the FFE, and that neither function can be performed separately by an SBE–FPs at this time. We did not receive any comments on this proposal and are finalizing the policy as proposed.

c. Annual Open Enrollment Period (§ 155.410)

We proposed to amend paragraph (e) of § 155.410, which provides the dates for the annual open enrollment period in which qualified individuals may apply for or change coverage in a QHP. We proposed to amend paragraph (e)(2) to define the open enrollment period for coverage year 2017 to be November 1, 2016, through January 31, 2017. We also proposed to amend the annual open enrollment period coverage effective date provisions in paragraphs (f)(2)(i) through (iii) to include the coverage effective dates for 2017.

We proposed this time period and these coverage effective dates to remain consistent with the 2016 open enrollment period. This timeframe will continue to partially overlap with the annual open enrollment period for Medicare and most employer offerings, which will benefit consumers by facilitating smooth transitions between coverage and creating process efficiencies for issuers handling enrollments and re-enrollments during the same period.

We also sought comment on what the open enrollment period for coverage year 2018 and subsequent years should be.

We are finalizing the open enrollment period for coverage year 2017 as proposed.

In response to comments received, we are similarly defining, at § 155.410(e)(2), the open enrollment period for coverage year 2018 to be November 1, 2017 through January 31, 2018. These are the same start and end dates as for the open enrollment periods for the 2016 and 2017 benefit years. We define the coverage start dates for all open enrollment periods beginning with the open enrollment period for the 2016 benefit year, in three paragraphs at § 155.410(f)(2). Accordingly, for example, for the 2018 coverage year, the Exchange must ensure that coverage is effective January 1, 2018, for QHP selections received by the Exchange on or before December 15, 2017; February 1, 2018, for QHP selections received by the Exchange on or before January 15, 2018; and March 1, 2018, for QHP selections received by the Exchange on or before January 31, 2018, and similarly for other coverage years. We believe that this open enrollment period provides sufficient time for operational readiness by the FFE and issuers, and provides consistency for consumers and sufficient time for them to enroll in coverage. However, as further explained below, we plan to shift to an earlier open enrollment end date for future open enrollment periods, starting with the open enrollment period for the 2019 coverage year, and are therefore finalizing at § 155.410(e)(3) an open enrollment period for all future coverage years to run from November 1 through December 15 of the year prior to the coverage year, with coverage effective the first day of the coverage year.

Comment: We received support from most commenters for maintaining the same open enrollment period for coverage year 2017 as for coverage year 2016, as it provides consistency for consumers, reduces consumer confusion about coverage effective dates, and continues to partially overlap with the open enrollment period for Medicare and for most employer offerings. We received several comments requesting an earlier open enrollment period that ends prior to the start of the benefit year and several comments requesting a later open enrollment period that continues through the Federal tax-filing season. Several commenters requested shortening the open enrollment period for the 2017 coverage year by two weeks, while other commenters requested lengthening the open enrollment period by a month or through part of the Federal tax filing season.

Response: After consideration of the comments, we are finalizing the open enrollment period for coverage year 2017 as proposed, for consistency with the 2016 open enrollment period, as discussed above.

Comment: We received varied comments regarding the open enrollment period for coverage year 2018 and for future coverage years. Many commenters recommended shifting to an earlier open enrollment period that starts and ends prior to the start of the coverage year, so that all consumers have a full year of coverage. Among these commenters, some recommended shortening the open enrollment period by two weeks for an open enrollment period that starts on October 1 and runs through December 15. Some of these commenters recommended shortening the duration of the open enrollment period from 3 months to 2 months for an open enrollment period that starts on October 15 and runs through December 15. Other commenters recommended shortening the duration of the open enrollment period to about six weeks, so it starts on November 1 and runs through December 15. Several commenters recommended an open enrollment period that starts on October 15 and runs through either December 7 or December 15 in order to align the Exchange and Medicare open enrollment periods.

Commenters opposed to an earlier open enrollment period start date expressed concerns about providing sufficient time for plans to be certified and for plans to be previewed prior to the start of the open enrollment period. Those opposed to an earlier open enrollment period end date expressed concern about consumer confusion over the enrollment deadline. And, those opposed to shortening the duration of the open enrollment period expressed concerns about the workforce constraints of assisters, such as Navigators and certified application counselors, agents, and brokers who provide enrollment assistance throughout the open enrollment period.

Several commenters recommended a gradual shift to an earlier open enrollment period. These commenters stressed the importance of enabling consumers to enroll in coverage in January, since many consumers travel or are otherwise occupied during the last few months of the year. Among these commenters, some recommended maintaining the same open enrollment period duration of 3 months for an open

[47] Federally-facilitated Marketplace and Federally-facilitated Small Business Health Options Program Enrollment Manual, updated October 1, 2015, section 6.1, available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated_ENR_Manual.pdf.*

enrollment period that starts on October 15 and runs through January 15. Other commenters recommended shortening the open enrollment period by approximately two weeks and keeping the same open enrollment start dates as for coverage years 2016 and 2017, for an open enrollment period that starts on November 1 and runs through January 15. Lastly, some of these commenters recommended shortening the open enrollment period to 2 months for one that starts on November 15 and runs through January 15.

Several other commenters recommended maintaining the same open enrollment period for 2018 and for future coverage years as for coverage years 2016 and 2017. Doing so, these commenters point out, would allow for better planning and consistency. Many of these commenters also recommended that HHS establish an open enrollment period for all future benefit years, which would enable issuers to engage in longer term planning, assist with outreach and enrollment efforts, and reduce consumer confusion.

Lastly, many commenters recommended a later closing of the open enrollment period to better align with the Federal tax filing season. These commenters noted that it is through the Federal tax filing process that many consumers have learned about the individual shared responsibility coverage requirement. While all of these commenters agreed that the duration of the open enrollment period should be extended, commenters were divided about whether the start of the open enrollment period should be the same as for the 2016 and 2017 coverage years, November 1, or should start slightly later on November 15. These commenters were also divided about whether the open enrollment period should continue through most of the tax filing season by continuing through March 15 or whether the open enrollment period should continue past the April tax-filing deadline to run through April 30. However, the majority of these commenters recommended an open enrollment period that begins on November 15 and runs through March 15.

Response: After consideration of the comments received, we are finalizing an open enrollment period for 2018 that starts on November 1, 2017 and runs through January 31, 2018. Maintaining the same open enrollment period start and end dates for coverage years 2016 through 2018, will provide consistency for consumers and will avoid putting new pressure on the QHP certification timeline for issuers. An open enrollment period end date of January 31 ensures that consumers are enrolled by March, which supports coverage for most consumers for the majority of the 2018 coverage year and does not put any new burdens on assisters, such as Navigators and certified application counselors, agents, brokers, and others providing enrollment assistance. However, to support a full year of coverage for most consumers, we plan to shift to an earlier open enrollment end date for the 2019 open enrollment period and all future open enrollment periods. Starting with the 2019 coverage year and beyond, we are setting an open enrollment period that runs through December 15. This change achieves our goals of shifting to an earlier open enrollment so that all consumers who enroll during this time will receive a full year of coverage and this will reduce selection risk for issuers. We believe that shifting the open enrollment period end date to December 15 for the 2019 coverage year provides sufficient time for all entities involved in the annual open enrollment period process, including Exchanges and issuers, to make the necessary adjustments to meet this earlier deadline. We also believe that, as the Exchanges grow and mature, a month-and-a-half open enrollment period provides sufficient time for consumers to enroll in or change QHPs for the upcoming coverage year.

d. Special Enrollment Periods (§ 155.420)

Special enrollment periods are available to consumers under a variety of circumstances as described in § 155.420. We stated in the proposed rule that we had heard concerns regarding abuse of special enrollment periods, and we sought comments and data regarding existing special enrollment periods.

In order to review the integrity of special enrollment periods, the FFE will be conducting an assessment under which we collect and review documents from consumers to confirm their eligibility for the special enrollment periods under which they enrolled. We note that where an Exchange undertakes such a review, the Exchange may either retroactively or prospectively end coverage, consistent with Exchange regulations, if the Exchange determines that the special enrollment period was improperly granted under § 155.420.

Comment: We received many comments related to amending the number and scope of special enrollment periods. Several commenters requested the addition of new special enrollment periods, including special enrollment periods for pregnancy and for individuals facing the individual shared responsibility payment at tax time. Other commenters requested the expansion of existing special enrollment periods, including adding provider network and drug formulary errors to the special enrollment period for plan or benefit display errors under paragraph (d)(4) of this section, allowing dependents of Indians to enroll in or change enrollments along with the Indian through the special enrollment period in paragraph (d)(8) of this section, and allowing for a retroactive coverage start date for consumers who qualify for the special enrollment period due to a loss of minimum essential coverage in paragraph (d)(1) of this section. Several commenters requested expansions to the timeframe and applicability of special enrollment periods, including extending the length of time in which a consumer may enroll after qualifying for a special enrollment period from 60 to 90 days, and extending all special enrollment periods offered through the Exchange to the off-Exchange market.

Other commenters requested restrictions in the number and availability of special enrollment periods. One commenter requested the elimination of all special enrollment periods that do not align with those special enrollment periods offered by Medicare or are not required by HIPAA, while another commenter stated that special enrollment periods should be limited to certain life-changing events. One commenter requested restricting the eligibility of the special enrollment period for gaining access to new QHPs as a result of a permanent move to only consumers who were previously enrolled in other minimum essential coverage, and only allowing the new dependent to enroll in or change his or her enrollment into a new QHP under the special enrollment period described in paragraph (d)(2). One commenter requested that States with SBE–FPs have the flexibility to establish State-specific special enrollment periods to address the particular needs of consumers in their State.

Response: We are not finalizing new qualifying events, eliminating current qualifying events, or changing the scope of current qualifying events for special enrollment periods at this time, but are continuing to study this issue. As explained in guidance released on January 19, 2016,[48] HHS has removed

[48] Special Enrollment Periods No Longer Utilized by the Federally-facilitated Marketplaces and State-based Marketplaces using the Federal Platform and Future CMS Actions (Jan. 19, 2016), available at *https://www.regtap.info/uploads/library/ENR_RetiredSEPs_011916_v1_5CR_011916.pdf;* see also FAQs on the Marketplace Residency Requirement

certain special enrollment periods that were available in 2014 and 2015 because the specified time period has ended, the situation it addressed has been resolved, or needed system updates have been made. HHS continues to review rules and guidance related to special enrollment periods.

Comment: Commenters expressed concerns about current misuse or abuse of special enrollment periods, including consumers who inappropriately obtain a special enrollment period on the basis of a loss of minimum essential coverage after being terminated from coverage due to a failure to pay premiums in violation of § 155.420(e)(1). Some commenters supported more clearly defining the eligibility parameters of existing special enrollment periods, as well as the consequences for inappropriately utilizing a special enrollment period to enroll in coverage.

In response to our request for comment and data to assess whether special enrollment periods are being abused and to minimize potential misuse and abuse of special enrollment periods, commenters expressed strong support for the Exchange to take actions to verify consumer eligibility for special enrollment periods moving forward, including requesting documentation supporting consumers' eligibility for special enrollment periods. Several commenters requested that the Exchange require consumers to submit documentation to either the Exchange or issuers to verify their eligibility for a special enrollment period. Some commenters noted that requesting such documentation at the time of the eligibility determination and before coverage has begun is least burdensome for consumers and is preferred by issuers. To aid in verification of special enrollment period eligibility, one issuer suggested implementing an online directory for issuers of consumers who have been terminated due to nonpayment of premiums. Some commenters requested that, until such verification has taken place, coverage not be effectuated under the special enrollment period. Other commenters suggested that the coverage of consumers who were ultimately found to be ineligible for special enrollment periods which they used to enroll in coverage or did not submit the necessary documentation in a timely manner should be canceled as of the date the enrollment became effective.

Conversely, other commenters expressed concern about the elimination or limitation of existing special enrollment periods without documented proof of abuse. Commenters stressed the important role special enrollment periods play in providing access to needed coverage for consumers throughout the year. Commenters encouraged HHS to analyze how consumers access special enrollment periods by using available data sources, and encouraged HHS to look at the findings by SBEs that have already conducted similar analyses. In addition, commenters cautioned against ending a consumer's coverage unless fraud has been proven.

Response: We appreciate the important concerns being raised regarding this issue. We believe it is important that consumers and others providing enrollment assistance understand the eligibility criteria for special enrollment periods, and so we will consider providing additional clarification around existing special enrollment periods. We continue to be interested in better understanding how consumers are accessing special enrollment periods and whether they are doing so in an appropriate and accurate way. In light of the strong support commenters expressed for verifying eligibility for special enrollment periods, we intend to conduct an assessment of QHP enrollments that have been made through special enrollment periods in the FFE to ensure that consumers properly accessed coverage and will require documentation for select SEPs going forward, as described in recent guidance posted on February 24, 2016.[49]

e. Termination of Coverage (§ 155.430)

Under current rules, § 155.430(b)(1) requires an Exchange to permit an enrollee to cancel or terminate his or her coverage in a QHP following appropriate notice to the Exchange or the QHP issuer. We proposed to add paragraph (b)(1)(iv) to allow an enrollee to retroactively cancel or terminate his or her enrollment in a QHP through the Exchange in very limited circumstances. For enrollees whose enrollment or continued enrollment in a QHP resulted from an error, misconduct, or fraud committed by an entity other than the enrollee, we aim to increase flexibility under the regulations to permit such enrollees to avoid the consequences of that entity's actions by canceling the QHP coverage. To this end, we proposed to redesignate current paragraph (b)(2)(vi) as (b)(2)(vii) and add a new paragraph (b)(2)(vi) to permit the Exchange to cancel an enrollee's enrollment in a QHP under certain circumstances. This rule would permit cancellations of fraudulent enrollments that the Exchange discovers, even if the enrollee is never aware of the enrollment.

We proposed new paragraph (b)(1)(iv)(A), which would permit an enrollee to retroactively terminate his or her coverage or enrollment if he or she demonstrates to the Exchange that he or she attempted to terminate his or her coverage or enrollment and experienced a technical error that did not allow the enrollee to effectuate termination of his or her coverage or enrollment through the Exchange. Such an enrollee would have 60 days after he or she discovered the technical error to request retroactive termination.

We proposed a new paragraph (d)(9), which would provide that the retroactive termination date under paragraph (b)(1)(iv)(A) would be no sooner than 14 days after the earliest date that the enrollee could demonstrate that he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless the issuer agrees to an earlier effective date as set forth in § 155.430(d)(2)(iii).

We proposed in paragraph (b)(1)(iv)(B) to provide for cancellation for an enrollee who demonstrates to the Exchange that his or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such an enrollee would have 60 days from the point he or she discovered the unintentional, inadvertent, or erroneous enrollment to request cancellation. In determining whether an enrollee has demonstrated to the Exchange that his or her enrollment meets the criteria for cancellation under this paragraph, the Exchange would examine the totality of the circumstances surrounding the enrollment, such as whether the enrollee was enrolled in other minimum essential coverage at the time of his or her QHP enrollment and whether he or she submitted claims for services rendered to the QHP. These factors would serve to indicate the intentions of the enrollee and whether the enrollment really was undesired and unintended and would be weighed in making a

and the Special Enrollment Period due to a Permanent Move (Jan. 19, 2016), available at *https://www.regtap.info/uploads/library/ENR_FAQ_ResidencyPermanentMove_SEP_5CR_011916.pdf.*

[49] 2017 Final HHS Notice of Benefit and Payment Parameters Fact Sheet. February 24, 2016. Available at, *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html#Premium.*

determination whether a cancellation is warranted. We sought comment on what other factors are indicative of an enrollee's bona fide intent and could limit gaming and should be considered in this analysis.

In new paragraph (b)(1)(iv)(C), we proposed to allow cancellations for enrollees who are enrolled in a QHP without their knowledge or consent due to the fraudulent activity of any third party, including third parties who have no connection with the Exchange. Such an enrollee would have 60 days from the point at which he or she discovered the fraudulent enrollment to request cancellation.

We proposed new paragraph (d)(10), which would provide that for cancellation or retroactive terminations granted in accordance with paragraphs (b)(1)(iv)(B) and (C), the cancellation or termination date would be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

Finally, under our current rules, § 155.430(b)(2) allows the Exchange to initiate termination of an enrollee's coverage or enrollment in a QHP through the Exchange, and permits a QHP issuer to terminate such coverage or enrollment in certain circumstances. We proposed to amend paragraph (b)(2)(ii)(A) to reflect the change to § 156.270(d) and (g) that gives an enrollee who, upon failing to timely pay premium, is receiving APTC, a 3-month grace period.

We also proposed in new paragraph (b)(2)(vi) that the Exchange could cancel an enrollee's enrollment that the Exchange determines was due to fraudulent activity, including fraudulent activity by a third party with no connection with the Exchange. New paragraph (d)(11) would provide that for cancellations granted in accordance with paragraph (b)(2)(vi), the cancellation date would be the original coverage effective date. The Exchange only would send the cancellation transaction following reasonable notice to the enrollee (recognizing that where no contact information or false contact information is available that notice may be impossible or impracticable).

We noted that our current guidance recognizes that at some point, the Exchange must discontinue the ability for enrollees to retroactively adjust coverage for the preceding coverage year. We stated that we are considering codifying a deadline for requesting cancellations or retroactive terminations.

We received the following comments concerning the proposed provisions around retroactive terminations and cancellations.

Comment: Most commenters supported the proposed ''60-days from discovery'' window for requesting the termination, while a few commenters suggested shorter windows (30–45 days). A few commenters agreed with the importance of providing a date after which retroactive terminations and cancellations will no longer be granted for the preceding coverage year.

Response: We chose 60 days to align with our standard 60-day special enrollment period window under § 155.420. We recognize the need to discontinue the ability for enrollees to retroactively adjust coverage for the preceding coverage year at some point. To that end, HHS issued a cut-off date in 2015 after which retroactive terminations through the FFE for 2014 coverage would no longer be granted, with the exception of those cases adjudicated through the appeals process. In determining the cut-off date for terminations of enrollments through FFEs and SBE–FPs for future years, we want to balance the operational needs of issuers and potential future functionality changes to the FFEs' enrollment system against the need to provide adequate time to identify and address erroneous, unknown, or nonconsensual enrollments through retroactive terminations and cancellations. Accordingly, we are codifying a provision permitting the Exchange to set a date after which retroactive terminations and cancellations will no longer be granted for the preceding coverage year, with the exception of those cases adjudicated through the appeals process, based on these factors.

Comment: Many commenters supported our proposal to permit retroactive terminations for enrollees who experienced a technical error by the Exchange that prevented them from terminating their coverage. Some supporters noted enrollees sometimes face challenges in terminating coverage timely. Two commenters suggested we make the effective date of termination the date of the demonstrated attempt, rather than 14 days following the attempt. A few commenters expressed concerns about potential gaming.

Response: This 14-day window proposed aligns with the regulation on voluntary, enrollee-initiated prospective terminations, and we note that issuers may permit earlier effective dates of terminations under § 155.430(d)(2)(iii). To minimize any opportunities for gaming, the Exchange will make these determinations based on research performed by HHS caseworkers.

Comment: Many commenters endorsed our proposal to permit retroactive terminations and cancellations for enrollees whose enrollment was unintentional, inadvertent, or erroneous and was the result of Exchange error or misconduct, citing examples of enrollments occurring under these circumstances and stressing the importance of this protection for consumers against undue financial burden. One commenter felt the provision did not go far enough to adequately protect a Medicaid-eligible enrollee who is unaware of his or her Medicaid eligibility or unaware of his or her ineligibility for the premium tax credit. A few commenters expressed concern about harm to the risk pool and the stability of the Exchanges through gaming. They noted limitations in the Exchange's ability to verify eligibility for special enrollment periods. One commenter recommended that enrollees only be permitted to initiate retroactive terminations or cancellations when permitted under State law or in the case of death. A few others recommended no retroactive terminations or cancellations be granted if premiums were paid or claims were incurred.

Response: We understand issuers' concerns regarding adverse selection if retroactive terminations or cancellations are granted without merit. Our aim is to provide these types of retroactive terminations or cancellations only for enrollees who were clearly harmed by an error or misconduct. It is not intended for enrollees who either simply did not understand the rules of their enrollment when they enrolled and want to reduce any tax liability they face due to ineligibility for the premium tax credit, or who wish to retroactively drop coverage when they realize they did not use it. We expect these terminations and cancellations to be granted rarely and only following thorough research of the facts and circumstances. To that point, the FFE will make these determinations only based on research performed by HHS caseworkers.

Comment: Several commenters commented on our provisions around granting enrollee-initiated and Exchange-initiated retroactive cancellations in cases involving fraudulent activity. Supporters cited examples of enrollee harm due to fraudulent activity by agents and brokers. A few commenters noted that coverage would not be effectuated without a binder payment and that member materials would be sent that would signify enrollment. A few commenters felt this authority is already permitted under issuers' rescission

authority (§ 147.128(a)(1)). One recommended we align the language with the language around agent and broker fraud in § 155.220. Others recommended that we clearly define fraud and ensure verification of instances of fraud.

Response: These proposed rules around cancellations for fraudulent activity are intended, in part, to address concerns regarding individuals who may have been enrolled without their knowledge or consent, potentially resulting in adverse tax consequences. In some cases, the enrollee may not discover the enrollment in time to request cancellation on his or her own behalf.

We recognize the legal and administrative complexities involved in determining fraud and we understand the importance of making this rule narrow enough to prevent abuse, but not so narrow that it could never be used. To that end, we are finalizing paragraphs (b)(1)(iv)(C), (b)(2)(vi), and (d)(11), except that we are replacing references to fraud with references to enrollments performed without enrollee ''knowledge or consent.'' In addition, in paragraph (b)(1)(iv)(C), we are adding that the enrollee must ''demonstrate to the Exchange'' that he or she was enrolled without his or her knowledge or consent.

Comment: Some commenters suggested retroactive terminations or cancellations in circumstances other than those we proposed. For example, a few commenters recommended that the Exchange retroactively terminate or cancel enrollments granted under special enrollment periods for which the enrollee was not truly eligible. Another commenter recommended we not permit retroactive cancellation when a consumer does not pay his or her premium in the fourth quarter, and then moves to a different plan during open enrollment with coverage effective January 1. Another commenter recommended we create parameters to permit retroactive terminations or cancellations in instances of credit card theft. Finally, one commenter recommended we allow termination without penalty to auto-enrollees in the first 60 days of the year, or due to confusion over covered benefits or providers.

Response: We understand the commenters' concerns; however, this proposed rule was limited to scenarios involving technical errors, misconduct or fraudulent activity. We address some of our future activities around special enrollment periods elsewhere in this rule. We are finalizing the provisions proposed in § 155.430 of the proposed rule with a few modifications. Specifically, as discussed above, we are eliminating references to fraud in paragraphs (b)(1)(iv)(C), (b)(2)(vi), and (d)(11) and referring instead to enrollments performed without the enrollee's knowledge or consent. We believe that in certain cases a retroactive termination can be justified where the enrollment was performed without knowledge or consent, even if fraud did not occur. In paragraph (b)(2)(vi), we also clarify that the enrollment performed without the enrollee's knowledge or consent could be performed by a third party that has no connection with the Exchange. In addition, for consistency with paragraphs (b)(1)(iv)(A) and (B), in paragraph (b)(1)(iv)(C), we are requiring that the enrollee ''demonstrates to the Exchange'' that he or she was enrolled without his or her knowledge or consent. Finally, as described in response to comments above, we are adding a new paragraph (d)(12) permitting the Exchange to establish a timeframe during which retroactive terminations and cancellations for the preceding coverage year must be initiated.

6. Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. General Eligibility Appeals Requirements (§ 155.505)

In § 155.505, we made certain proposals related to the general eligibility appeals requirements. We proposed to add paragraph (b)(1)(iii) to state more clearly that applicants and enrollees have the right to appeal a determination of eligibility for an enrollment period. We also proposed to add paragraph (b)(5) to clarify the existing right under § 155.520(c) that applicants and enrollees have to appeal a decision issued by the State Exchange appeals entity. In paragraph (b)(4), we proposed to correct a typographical error by replacing the word ''or'' with the word ''of,'' and to replace ''pursuant to'' with ''under.''

We are finalizing the changes as proposed.

Comment: Commenters all supported the proposal to clarify the existing rights to appeal a determination of eligibility for an enrollment period and appeal a decision issued by the State Exchange appeals entity. One commenter sought clarification that the change to § 155.505(b)(5), related to the right to appeal a decision issued by a State Exchange appeals entity, applies only to Exchange decisions related to eligibility for enrollment in a qualified health plan and financial assistance through the Exchange, but not Medicaid or CHIP.

Response: In certain circumstances, it is possible that a State Exchange appeals entity appeal decision regarding eligibility for Medicaid, CHIP, or the BHP could be escalated to and adjudicated by the HHS appeals entity. However, as discussed below, at the time of publication of this final rule, no State agency administering Medicaid, CHIP, or the BHP has delegated appeals to the State Exchange appeals entity in a manner that would permit the HHS appeals entity to adjudicate these appeals. Therefore, we confirm that the right to appeal a decision issued by a State Exchange appeals entity under § 155.505(b) currently is limited to decisions related to eligibility for enrollment in a qualified health plan through the Exchange (including enrollment periods), Exchange financial assistance, exemptions from the individual shared responsibility requirement, and denials of requests to vacate dismissals by the State Exchange appeals entity.

As we explained in the final rule in the July 15, 2013 **Federal Register** (78 FR 42160), States may choose to delegate authority to conduct Medicaid fair hearings for MAGI-based eligibility determinations to the Exchange operating in the State regardless of whether the Exchange is an FFE, State Exchange, or a State Partnership Exchange, in accordance with the Medicaid regulations at 42 CFR 431.10(c) and (d). If a State agency delegates authority to conduct MAGI-based eligibility appeals to an Exchange, including a State Exchange, in accordance with 45 CFR 431.10(c) and (d), such a delegation would extend to the HHS appeals entity, if the State Exchange appeals entity's appeal decision were escalated under § 155.505(c)(2)(i).

However, States with State Exchanges that are State governmental agencies may also coordinate appeals, beyond delegation under our rules, through a waiver granted under the Intergovernmental Cooperation Act. If a State delegates authority to conduct fair hearings through an Intergovernmental Cooperation Act waiver to another State agency, including a State Exchange or State Exchange appeals entity, Medicaid appeal decisions made by that entity could not be escalated to the HHS appeals entity (78 FR 42,160, 42,165 (July 15, 2013)).

As of this publication, all State Exchanges have coordinated appeals through an Intergovernmental Cooperation Act waiver, and therefore Medicaid appeal decisions made by a

State Exchange appeals entity are not appealable to the HHS appeals entity under § 155.520(c) or § 155.505(b)(5).

b. Appeals Coordination (§ 155.510)

We proposed to revise § 155.510(a)(1) to allow the appeals entity, the Exchange, or the agency administering insurance affordability programs to request information or documentation from the appellant that the appellant already has provided if the agency does not have access to such information or documentation and cannot reasonably obtain it. Currently, § 155.510(a)(1) prohibits the appeals entity or agency administering insurance affordability programs from asking an appellant to provide information or documentation that the appellant already provided in order to minimize the burden on the appellant.

We are finalizing our proposal, with an addition as described below.

Comment: Commenters all supported the proposed change to § 155.510(a)(1). A few commenters cautioned that the proposed amendment to paragraph (a)(1) should not overly burden appellants and recommended that it be used as a time-limited, interim measure until system functionality improves.

Response: We agree that proposed paragraph (a)(1) should not overly burden appellants. As proposed, paragraph (a)(1) permits the appeals entity, Exchange, or agency administering insurance affordability programs to request information or documentation from the appellant if the agency does not have access to such information or documentation and cannot reasonably obtain it. To further ensure that paragraph (a)(1) does not overly burden appellants, we are finalizing paragraph (a)(1) to also require that the information or documentation requested is necessary to properly adjudicate the appellant's appeal. We believe that the addition of this language will minimize any unnecessary burden on the appellant while also ensuring that appeals are adjudicated accurately.

c. Appeal Requests (§ 155.520)

We proposed to add paragraph (d)(2)(i)(D), concerning appellants whose appeal request is determined invalid for failure to request an appeal by the date determined in paragraph (b) or (c) of this section. The proposed addition would require the appeals entity to notify an appellant that, in the event the appeal request is invalid because it was not timely submitted, the appeal request may be considered valid if the applicant or enrollee demonstrates within a reasonable timeframe determined by the appeals entity that failure to timely submit was due to exceptional circumstances and should not preclude the appeal.

We proposed that the appeals entity may determine what constitutes an exceptional circumstance that should not preclude an appeal notwithstanding the appellant's failure to timely submit an appeal request. We also proposed that the appeals entity may determine what is considered a reasonable timeframe for an appellant to demonstrate an exceptional circumstance.

We are finalizing the provision as proposed.

Comment: Commenters supported the proposed change to § 155.520(d)(2)(i)(D). A few commenters requested additional examples or guidelines as to what constitutes an ''exceptional circumstance'' such that failure to timely submit an appeal request should not preclude an appeal. Commenters also requested additional guidance on what constitutes a ''reasonable timeframe'' to demonstrate an exceptional circumstance. One SBE supported the proposed amendment as long as Exchange appeal entities have the flexibility to determine what constitutions an exceptional circumstance and a reasonable timeframe.

Response: In the proposed rule, we provided several examples of situations that might constitute an exceptional circumstance under proposed paragraph (d)(2)(i)(d). We stated that a weather emergency, such as a blizzard, hurricane or tornado, may constitute an exceptional circumstance. We discussed scenarios in which severe weather causes a power outage making it impossible to prepare, mail, or fax appeal requests to the appeals entity, and situations when a disaster may cause consumers to lose access to the documents they need to complete and submit appeal requests. We also noted that if a consumer suffers a catastrophic medical event and is consequently unable to submit an appeal request on time, the appeals entity may determine that this constitutes an exceptional circumstance under the proposed exception.

We also provided guidance in the proposed rule as to what constitutes a reasonable timeframe to demonstrate an exceptional circumstance. We stated that if an appellant was unable to send an appeal request on time due to a snow storm and power outage and sent the request four months after the snow storm and power outage had been resolved, the appeals entity may find that the appellant experienced an exceptional circumstance as contemplated by the proposed rule, but that the appellant waited an unreasonable amount of time to demonstrate it.

The examples above provide guidance to appellants and representatives as to what the appeals entity may consider an exceptional circumstance such that failure to timely submit an appeal request should not preclude an appeal, and a reasonable timeframe to demonstrate an exceptional circumstance. We intend for these examples to be illustrative and not exhaustive, and believe that the appeals entity should decide on a case-by-case basis whether an appeal request that is invalid due to untimely submission nevertheless should be allowed to proceed under paragraph (d)(2)(i)(d).

d. Dismissals (§ 155.530)

We proposed to revise § 155.530(a)(4) to allow an appeal to continue when an appellant dies if the executor, administrator, or other duly authorized representative of the estate requests to continue the appeal.

Comment: Commenters supported the proposed change to § 155.530(a)(4). A few commenters also recommended allowing a spouse, partner, parent, or guardian of a deceased appellant to continue an appeal. They believed this may be necessary when an appellant, especially a child or incapacitated adult, has not gone through the legal process of establishing an executor, administrator, or other duly authorized representative. In such cases, the commenters recommend allowing a family member to step into the shoes of the deceased appellant to prevent the dismissal of an appeal from imposing a financial hardship on the surviving members of the family.

Response: We agree with the commenters. Therefore, we are clarifying that if a deceased appellant has not designated an executor, administrator, or other duly authorized representative, and one has not been appointed by the court, the deceased appellant's spouse, legal civil or domestic partner, or for a minor or unmarried incapacitated appellant, parent or legal guardian, is considered a duly authorized representative and may continue the appeal.

We are finalizing § 155.530(a)(4) as proposed.

e. Informal Resolution and Hearing Requirements (§ 155.535)

In § 155.535, we proposed amendments to the informal resolution and notice of hearing requirements. In § 155.535(a), we proposed a change to

clarify that the requirements of the informal resolution process described in paragraphs (a)(1) through (4) apply to both the HHS appeals entity and a State Exchange appeals entity.

In § 155.535(b), we proposed providing two exceptions to the requirement that the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date. In paragraph (b)(1), we proposed an exception when an appellant requests an earlier hearing date. In paragraph (b)(2), we proposed an exception to the notice requirement under paragraph (b) when a hearing date sooner than 15 days is necessary to process an expedited appeal, as described in § 155.540(a), and the appeals entity and appellant have mutually agreed to the date, time, and location or format of the hearing. These proposals were intended to create a more agreeable experience for the appellant overall while also improving efficiency for the appeals process.

Comment: The comments received on these proposed changes were largely supportive. Commenters recommended that if written notice is not sent to an appellant under paragraph (b)(2), then the appeals entity must contact both the appellant and the appellant's authorized representative, if any, to agree upon a date, time, and location or format of the hearing.

Response: We agree with the commenter's recommendation. The simple act of contacting the appellant's authorized representative could reduce the likelihood of an unintended failure to appear that could harm both the appellant and the overall efficiency of the appeals process. This may be especially true for limited-English proficient appellants who should not suffer the harsh consequences because of a language barrier.

We are finalizing § 155.535(a) and (b)(1) as proposed. We are finalizing § 155.535(b)(2) to allow an exception to the notice requirement under paragraph (b) when a hearing date sooner than 15 days is necessary to process an expedited appeal, as described in § 155.540(a), and the appeals entity, has contacted the appellant and appellant's authorized representative, if any, to schedule a hearing on a mutually agreed to date, time, and location or format.

f. Appeal Decisions (§ 155.545)

In paragraph (b)(1), we proposed to remove the third appearance of the word ''of'' to correct a typographical error. We proposed to revise paragraph (c)(1)(i) to include cross references to § 155.330(f)(4) and (5), which aligns with our proposed change § 155.505(b) to clarify that applicants and enrollees have the right to appeal a determination of eligibility for an enrollment period. Finally, we proposed to revise § 155.545(c)(1)(ii) so that the coverage effective date for eligible appellants requesting a retroactive appeal decision effective date is the coverage effective date that the appellant did receive or could have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal.

Comment: Commenters all supported the proposed changes to § 155.545. Some commenters recommended that, in the event the appeals entity takes more than 90 days to process an appeal through no fault of the appellant, the appellant may choose a coverage effective date that falls between the initial eligibility determination date and the date of the appeals decision. They pointed out that while waiting for an appeal to be adjudicated, an appellant may have experienced a health issue for which retroactive coverage would be helpful, but may not be in the financial situation to pay back premiums for more than a limited number of months.

Response: To remain consistent with other effective date regulations, we cannot permit an appellant to choose a coverage effective date that falls between the initial eligibility determination date and the date of the appeal decision, except in the limited circumstance described below. Existing effective date regulations including those at §§ 155.410(f), 155.330(f), and 155.420(b) allow for prospective or retroactive coverage effective dates, as appropriate, based on a triggering event such as an eligibility determination or the birth of a child. The special coverage effective dates for certain special enrollment periods under § 155.420(b)(2)(iii), which requires the Exchange to ensure a coverage effective date that is appropriate based on the circumstances of the special enrollment period, must be tied to a triggering event and may not be chosen by the qualified individual or enrollee.

In the event an appeals entity finds that an eligibility determination, as described in § 155.505(b)(1), was incorrect, and the appellant had more than one coverage effective date available in the enrollment period that the eligibility determination was made, the appellant may be permitted to choose a coverage effective date associated with the enrollment period. For example, if the appeals entity determines that an eligibility determination made on November 25, 2015 for the 2016 coverage year was incorrect, the appellant may choose a retroactive coverage effective date of January 1, 2016, February 1, 2016, or March 1, 2016 because the appellant would have had the opportunity to make a QHP selection between November 25, 2015 and January 31, 2016 and receive one of those coverage effective dates (depending on when the QHP was selected). Even in this situation, the appellant may choose only from among those coverage effective dates that would have been available under the original enrollment period, and may not chose any coverage effective date between the initial eligibility determination date and the date of the appeals decision.

Accordingly, we are finalizing paragraph (c)(1)(ii) as proposed, with one modification. Under the final regulation, an appeals entity may only implement an appeal decision retroactively to the coverage effective date the appellant did receive or could have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal. We are changing the phrase ''would have received'' to ''could have received'' to clarify that an eligible appellant may choose from among the coverage effective dates that would have been available under the original enrollment period.

g. Employer Appeals Process (§ 155.555)

We proposed to make a technical correction to § 155.555(e)(1) by removing the cross-reference to paragraph (d)(3) of this section, which does not exist, and replacing it with paragraph (d)(1)(iii).

We also proposed to amend § 155.555(l) by revising paragraph (l) and adding paragraphs (l)(1) and (2) to give the Exchange more operational flexibility in implementing an employer appeal decision. Currently under § 155.555(l), when an employer appeal decision affects an employee's eligibility, the Exchange is directed to redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable. We proposed to amend § 155.555(l) so that, after receipt of the notice from the appeals entity under paragraph (k)(3) of this section, the Exchange must follow the requirements in either paragraph (l)(1) or (2) if the appeal decision affects the employee's eligibility. Under proposed paragraph (l)(1), the Exchange must promptly redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable, in accordance with the standards specified in § 155.305, as currently provided in paragraph (l).

Under proposed paragraph (l)(2), the Exchange must promptly notify the employee of the requirement to report changes in eligibility as described in § 155.330(b)(1). We sought comment on the addition of the option described in paragraph (1)(2), and whether it would help ensure the most accurate redetermination of eligibility for insurance affordability programs by giving employees the opportunity to report any additional changes in their eligibility information.

We are finalizing § 155.555(l), and the technical correction to § 155.555(e)(1), as proposed.

Comment: Commenters generally supported the proposed addition of § 155.555(l)(2). Several commenters supported this change because it would give consumers the opportunity to update their application with any other changes that could affect eligibility which would result in a more accurate eligibility determination. One commenter provided an example of an applicant who had employer-sponsored coverage through his or her spouse at the time of applying for coverage through the Exchange, but later received a legal separation. One commenter who disagreed with the proposed addition of paragraph (l)(2) expressed concern that an employee who fails to update his or her eligibility may face a greater tax liability when filing his or her Federal tax return.

Response: As described in § 155.330(b)(1), an enrollee is required to report any change with respect to the eligibility standards specified in § 155.305 within 30 days of such change. Before enrolling in coverage through the Exchange, applicants for coverage must confirm their understanding that they must notify the entity administering the program they enroll in if information on their application changes, and that such changes may affect the eligibility for member(s) of their household. Nevertheless, we agree with commenters that the proposed change in § 155.555(l)(2) would give employees another opportunity to update their application with changes that affect their eligibility or the eligibility of household members when an appeal decision under § 155.555 affects the employee's eligibility. We are finalizing § 155.555(l) as proposed to permit the Exchange, after receipt of the notice under paragraph (k)(3) of this section, to follow either the requirements in either paragraph (l)(1) or (2) if the appeal decision affects the employee's eligibility. As stated in the proposed rule, for the 2016 benefit year, the FFE intends to implement appeal decisions that affects the employee's eligibility by following the procedure described in paragraph (1)(2).

Comment: One commenter who supported the proposed changes to § 155.555(l) wrote that, in order for the option described in paragraph (l)(2) to be meaningful, employees must have very clear instructions on how to update their application.

Response: We agree that a notice under § 155.555(l)(2) must provide clear instructions to the employee in order to be effective. For notices submitted by the FFE, we intend to provide guidance on reporting changes in information with respect to eligibility through the online application and the Marketplace Call Center, instructions on updating the online application questions to reflect that the employee has an offer of employer-sponsored coverage that provides minimum value and is affordable for the employee, and instructions on terminating enrollment in a QHP through the Exchange for those who want to terminate enrollment upon being redetermined ineligible for Exchange financial assistance.

Comment: Commenters suggested that the Exchange be required to follow the procedures outlined in both paragraphs (l)(1) and (2). They recommended that the Exchange send a notice under paragraph (l)(2) and, if an employee does not update his or her application within a specified period of time, the Exchange follow the procedure described paragraph (l)(1) to redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable.

Response: We are concerned that such a policy would cause considerable operational burden to the Exchange while providing minimal benefit to the employee. We believe that the policy as proposed balances the need for employees to receive an updated eligibility determination after an appeal decision affects the employee's eligibility, with the need to provide operational flexibility to the Exchange. Accordingly, we are finalizing this provision as proposed, to give the Exchange the option to follow either paragraph (l)(1) or (2) after receipt of the notice under paragraph (k)(3) of this section.

Comment: One commenter expressed concern that an employee who does not report his or her change in eligibility could place the employer at greater risk for an assessable payment under section 4980H of the Code.

Response: We disagree with the proposition that an employee who does not report his or her change in eligibility could place the employer at greater risk for being liable for an assessable payment under section 4980H of the Code. An employee is subject to the requirement to report a change in his or her eligibility under § 155.330(b)(1) when the appeals entity determines that his or her employer offered employer-sponsored coverage that provides minimum value and is affordable for the employee. Independently, the Internal Revenue Service (IRS) will determine whether an employer is liable for an employer shared responsibility payment based on the employer shared responsibility provisions.[50] If the IRS, in its own review, determines that an employee of an applicable large employer is ultimately not eligible for the premium tax credit under section 36B of the Code, then, in general, the employer will not owe an employer shared responsibility payment with respect to that full-time employee, even if the employee enrolled in a QHP with APTC (regardless of whether the employee reported a change with respect to eligibility to the Exchange following the outcome of an employer appeal).

7. Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions

a. Eligibility Standards for Exemptions (§ 155.605)

In § 155.605, we proposed to clarify and streamline policies related to exemptions. Consistent with prior guidance, we proposed to permit any applicant whose gross income is below his or her applicable filing threshold to qualify for a hardship exemption and claim the exemption through the tax filing process. In addition, we proposed to permit individuals eligible for services from an Indian health care

[50] In general, an applicable large employer (an employer with at least 50 full-time employees, including full-time equivalent employees) will owe an assessable payment to the IRS under section 4980H(a) of the Code if the employer fails to offer coverage to its full-time employees (and their dependents) and at least one full-time employee receives the premium tax credit. An assessable payment under section 4980H(a) of the Code is calculated based on the employer's number of full-time employees, without regard to how many full-time employees receive the premium tax credit. An applicable large employer will owe an assessable payment under section 4980H(b) of the Code if it offers coverage to its full-time employees (and their dependents) but at least one full-time employee receives the premium tax credit, which could occur if the coverage offered did not provide minimum value or was not affordable. (For purposes of section 4980H, coverage may be considered affordable under an affordability safe harbor even if the coverage is not affordable for purposes of section 36B of the Code. 26 CFR 54.4980H–5(e)(2)). An assessable payment under section 4980H(b) of the Code is calculated based on the number of full-time employees who receive the premium tax credit.

provider to claim a hardship exemption through the tax filing process. We proposed that for the 2016 tax year and later that the Exchange no longer issue exemption certificate numbers (ECNs) for the following exemption types: members of a Health Care Sharing Ministry, individuals who are incarcerated, members of Federally recognized tribes, and individuals who are eligible for services from an Indian health care provider. We also proposed to codify a list of other hardship exemptions previously established in prior guidance and to clarify operational standards for timeframes of hardship events and the duration of certain hardship exemptions. We are finalizing the policy of streamlining of exemptions offered through the tax filing process as proposed; however, at this time, we will not codify the list of hardship exemptions established in prior guidance and will not finalize the proposal to permit an individual to obtain a hardship exemption for a hardship experienced within 3 years of the date of application.

Comment: We received comments in favor of eliminating unnecessary paperwork for individuals seeking an exemption due to their State not expanding Medicaid coverage. Commenters also supported streamlining the exemption process for members of a Health Care Sharing Ministry, members of Federally recognized Indian tribes and individuals eligible for services from an Indian health care provider, and individuals who were incarcerated by delegating these exemption types fully to the IRS.

Response: In this final rule, we are finalizing the proposal to streamline the exemption application process for consumers and to minimize paperwork requirements for consumers in States that did not expand Medicaid coverage. We are finalizing the proposal to no longer require a denial notice for the hardship exemption for applicants ineligible for Medicaid because their State did not expand Medicaid coverage. In addition, we are finalizing the proposal to streamline exemption processing for members of a Health Care Sharing Ministry, individuals who are incarcerated, members of Federally recognized Indian tribes, and individuals who are eligible for services from an Indian health care provider.

Comment: We received comments supporting and opposing our proposal to codify hardship criteria established in regulatory guidance. Commenters stated that any expansion of the hardship exemption criteria could weaken the individual shared responsibility provision and create instability in insurance risk pools. In addition, we received a request for clarification of factors that an Exchange would examine in order to approve a hardship exemption.

Response: We will continue to examine these comments and will not codify the list of hardship exemptions previously established in public guidance at this time.

Comment: We received comments both in support of and against the proposal to allow individuals to apply for a hardship that occurred up to 3 calendar years in the past. Commenters who supported this proposal thought that it would provide greater flexibility for Exchanges to approve hardship exemptions. Commenters who did not support the proposal stated that 3 years was overly broad and could lead to a destabilization of a health insurance risk pool by providing an additional incentive for healthy consumers to claim an exemption in lieu of obtaining health coverage.

Response: In response to the concerns raised by commenters, we will not finalize § 155.605(d)(2) at this time. Similarly, we will not finalize the last sentence of the introductory paragraph of § 155.605(d)(1), which establishes a maximum length of any hardship exemption of the month before the circumstance, the remainder of the calendar year, and the next calendar year.

Comment: We received a suggestion that the Exchange establish an exemption for people who are erroneously determined ineligible for APTC and who do not enroll in a qualified health plan as a result.

We also received one comment that our proposal to codify the existing hardship exemption time period related to an appeal in § 155.605(d)(2)(xiv) should be expanded to include the date of application, rather than a consumer's potential coverage effective date. The commenter stated that the current timeframe is too narrow for individuals who were unable to file an appeal of an eligibility determination within 90 days due to the fact that a data inconsistency generated during the application process must be adjudicated before a consumer may file an appeal.

Response: We are not codifying § 155.605(d)(2)(xiv) at this time, but will continue to consider these issues and comments for future rulemaking.

b. Required Contribution Percentage (§ 155.605(e)(3))

Under section 5000A of the Code, an individual must have minimum essential coverage for each month, qualify for an exemption, or make a shared responsibility payment with his or her Federal income tax return. Under section 5000A(e)(1) of the Code, an individual is exempt if the amount that he or she would be required to pay for minimum essential coverage (the required contribution) exceeds a particular percentage (the required contribution percentage) of his or her actual household income for a taxable year. In addition, under § 155.605(g)(2) (redesignated as § 155.605(d)(2) in this final rule), an individual is exempt if his or her required contribution exceeds the required contribution percentage of his or her projected household income for a year. Finally, under § 155.605(g)(5) (redesignated as § 155.605(d)(5) in this final rule), certain employed individuals are exempt if, on an individual basis, the cost of self-only coverage is less than the required contribution percentage, but the aggregate cost of individual coverage through employers exceeds the required contribution percentage, and no family coverage is available through an employer at a cost less than the required contribution percentage.

Section 5000A established the 2014 required contribution percentage at 8 percent. For plan years after 2014, section 5000A(e)(1)(D) of the Code and 26 CFR 1.5000A–3(e)(2)(ii) provide that the required contribution percentage is the percentage determined by the Secretary of HHS that reflects the excess of the rate of premium growth between the preceding calendar year and 2013, over the rate of income growth for that period.

We established a methodology for determining the excess of the rate of premium growth over the rate of income growth for plan years after 2014 in the 2015 Market Standards Rule (79 FR 30302), and we said future adjustments would be published annually in the HHS notice of benefit and payment parameters.

Under the HHS methodology, the rate of premium growth over the rate of income growth for a particular calendar year is the quotient of (x) 1 plus the rate of premium growth between the preceding calendar year and 2013, carried out to ten significant digits, divided by (y) 1 plus the rate of income growth between the preceding calendar year and 2013, carried out to ten significant digits.[51]

As the measure of premium growth for a calendar year, we established in the 2015 Market Standards Rule that we

[51] We also defined the required contribution percentage at § 155.600(a) to mean the product of 8 percent and the rate of premium growth over the rate of income growth for the calendar year, rounded to the nearest one-hundredth of one percent.

would use the premium adjustment percentage. The premium adjustment percentage is based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary.[52] (Below, in § 156.130, we finalize the proposed 2017 premium adjustment percentage of 1.1325256291 (or an increase of about 13.3 percent) over the period from 2013 to 2016. This reflects an increase of about 4.9 percentage points (1.1325256291–1.0831604752) for 2015–2016.)

As the measure of income growth for a calendar year, we established in the 2015 Market Standards Rule that we would use per capita Gross Domestic Product (GDP), using the projections of per capita GDP used for the NHEA, which is calculated by the Office of the Actuary. We also stated in the 2015 Market Standards Rule (79 FR 30304), that we would-consider alternative measures of income and premium growth should projections of those measures become available. Subsequently, as part of its projections of National Health Expenditures, the Office of the Actuary published projections of personal income (PI) for the first time in September 2014 and subsequently in July 2015. As a result, in the proposed rule we said we were considering substituting this new measure of per capita PI for per capita GDP in the calculation for the required contribution percentage. We received one comment in support of our proposal to substitute per capita PI for per capita GDP in the calculation to establish the rate of income growth for the required contribution percentage, and are finalizing it here. As stated in the proposed rule, we believe per capita PI better aligns with the statutory intent of measuring the income of an individual than per capita GDP. The projections of PI published by the Office of the Actuary are consistent with the measure published by the Bureau of Economic Analysis, which reflects income received by individuals from all sources, including income from participation in production. Specifically, it includes compensation of employees (received), supplements to wages and salaries, proprietors' income with adjustments for inventory valuation and capital consumption, personal income receipts on assets, rental income, and personal current transfer receipts, less contributions for government social insurance.

The Office of the Actuary's PI projection is generated using the University of Maryland's Long Term Inter-industry Forecasting Tool. The Long Term Inter-industry Forecasting Tool model is a macro-economic model that is based on the historical relationships that exist between PI growth, GDP growth, and changes in other macro-economic variables. For instance, the correlation between PI and GDP is influenced by fluctuations in taxes and government transfer payments, depreciation of capital stock, and retained earnings and transfer payments of private business.[53] Estimates of GDP in the NHE projections reflect economic assumptions from the 2015 Medicare Trustees Report and are updated to incorporate the latest available consensus data from the monthly Blue Chip Economic Indicators. These same economic assumptions are used for producing projections of PI and employer-sponsored insurance premiums, so using this estimate will generate an internally consistent estimate of the growth in premiums relative to growth in income.

As stated in the proposed rule, we will continue to consider other changes to the measures of income per capita and premium growth as additional information becomes available and as we gain experience with the current measures; we received no comments on other indices that we should develop or consider.

Since updating the required contribution percentage for 2017 requires calculating the cumulative difference between premium growth and income growth between the preceding calendar year and 2013, we also proposed in the proposed rule to replace per capita GDP with per capita PI for all years beginning in 2013 and then calculate cumulative income growth through 2016. We received no comments on this retrospective approach, and are finalizing it here; as stated in the proposed rule, a retrospective approach allows for consistency across all years with the most recent data available. We note that potential future changes based on new data that are not available for 2013 may be made on a prospective basis.

Therefore, under the approach finalized here, and using the NHEA data, the rate of income growth for 2017 is the percentage (if any) by which the most recent projection of per capita PI for the preceding calendar year ($49,875 for 2016) exceeds the per capita PI for 2013, ($44,925), carried out to ten significant digits. The ratio of per capita PI for 2016 over the per capita PI for 2013, using the finalized approach for both years, is estimated to be 1.1101836394 (that is, per capita income growth of about 11.0 percent). This reflects an increase of about 3.0 percentage points (1.1101836394–1.0798864830) for 2015–2016.

Thus, using the 2017 premium adjustment percentage finalized in this rule, the excess of the rate of premium growth over the rate of income growth for 2013–2016 is 1.1325256291/1.1101836394, or 1.0201245892. This results in a required contribution percentage for 2017 of 8.00*1.0201245892, or 8.16 percent, when rounded to the nearest one-hundredth of one percent, an increase of 0.27 percentage points from 2016 (8.16100–8.13399). The excess of the rate of premium growth over the rate of income growth also is used for determining the applicable percentage in section 36B(b)(3)(A) and the required contribution percentage in section 36(c)(2)(C).

c. Eligibility Process for Exemptions (§ 155.610)

In § 155.610, we proposed adding new paragraph in § 155.610(k) which describes how the Exchange will handle incomplete exemption applications. We proposed that the Exchange will handle incomplete exemption applications in a similar manner to the procedure for handling incomplete health coverage applications established under § 155.310(k). Specifically, when the Exchange receives an application that does not contain sufficient information to make an eligibility determination, the Exchange will: (1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specify the missing information, and provide instructions for submitting the missing information; (2) provide the applicant with a period of no less than 10 and no more than 90 days starting from the date on which the notice is sent to the applicant to provide the information needed to complete the application to the Exchange; and (3) if the Exchange does not receive the requested information, then the Exchange will

[52] For any given year the premium adjustment percentage is the percentage (if any) by which the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for the current year exceeds the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2013.

[53] For projections of PI and GDP, see Table 1 at Centers for Medicare & Medicaid Services. National Health Expenditure Data: Projected, available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.*

notify the applicant that the Exchange will not process the application and will provide appeal rights to the applicant. We sought comment on this proposal.

Comment: We received comments which supported this proposal to handle incomplete exemption applications, however many commenters found the 10-day minimum timeframe to be too short and recommended a minimum of 30 days to submit missing information to the Exchange instead.

Response: We accept this recommendation, and will amend the regulation text to establish a minimum of 30 days from the date on which the notice is sent to an applicant to provide required information to the Exchange.

d. Verification Process Related to Eligibility for Exemptions (§ 155.615)

In § 155.615, we proposed to delete § 155.615(c), (d), (e), and (f)(3) to conform with a proposal under § 155.605 that would remove the ability for consumers to obtain an ECN from the Exchange for certain exemptions. We also proposed conforming redesignations of the remaining paragraphs under § 155.615. Elsewhere in this final rule, we are finalizing the relevant proposals under § 155.605. Accordingly, we are finalizing as proposed the deletions of paragraphs (c), (d), (e), and (f)(3) from § 155.615 and the conforming redesignations.

Comment: We received comments both in support of and against the 3-year period for exemption criteria under the proposed rule at § 155.605(d)(3) and the conforming amendment to § 155.615(c)(2).

Response: We will continue to consider the issues presented by commenters, and will not finalize § 155.615(c)(2) at this time.

e. Options for Conducting Eligibility Determinations for Exemptions (§ 155.625)

We proposed to amend § 155.625(a)(2) and (b) to remove the deadline after which a State Exchange would be required to process exemption applications for residents of the State by the start of open enrollment for 2016, and to instead permit an Exchange to adopt the exemption eligibility determination service operated by HHS indefinitely. Based on HHS's operation of this service to date, we have determined that the HHS exemption option is an efficient process for State Exchanges that has minimized confusion for consumers. This proposal follows an FAQ published on July 28, 2015 in which HHS stated that it will not take any enforcement action against State Exchanges that continue to use the HHS service for exemptions beyond the start of open enrollment for 2016.

Comment: We received one comment about this section that supports the recommendation to permit States to elect to use the HHS service for exemptions. This commenter also suggested that an SBE should be able to grant the hardship exemption established in § 155.605(d)(2) for lack of affordable coverage even if it does not process other exemptions, because the State would have the eligibility information needed to determine whether an individual qualifies for this exemption from an individual's health coverage application.

Response: We accept this comment and have amended the regulation text to permit a State Exchange to grant a hardship exemption to consumers the Exchange determines unable to afford coverage based on their projected annual household income under § 155.605(d)(2) regardless of whether the Exchange will grant other exemption types.

8. Exchange Functions: Small Business Health Options Program (SHOP)

a. Functions of a SHOP (§ 155.705)

In § 155.705, we proposed to add new paragraphs (b)(3)(viii) and (ix) to specify that the FF–SHOPs would provide additional options for employer choice for plan years beginning on or after January 1, 2017, namely a ''vertical choice'' option for QHPs and SADPs. Under this option, employers will be able to offer qualified employees a choice of all plans across all available levels of coverage from a single issuer. We noted that existing SHOP regulations at § 155.705(b)(3)(i)(B) and (b)(3)(ii)(B) provide State-based SHOPs with the flexibility to provide employers with vertical choice or other employer choice options in addition to ''horizontal choice,'' in which an employer selects a single actuarial value coverage level and makes all plans at that coverage level available to qualified employees. We did not propose to alter State-based SHOPs' flexibility in this regard, unless the State-based SHOP was relying on the Federal platform for SHOP enrollment functions.

We also sought comment on whether the FF–SHOPs should make other employer choice options available, including allowing participating employers to select an actuarial value level of coverage, after which employees could choose from plans available at that level and at the level above it, which we refer to below as ''contiguous choice.'' We also sought comment on whether to give the State in which the FF–SHOP is operating an opportunity to recommend whether the FF–SHOP in that State should implement any additional model of employer choice. However, in all States, the FF–SHOPs would continue to give employers the option of offering a single QHP (or single SADP) as well as the option of offering a choice of all QHPs (or SADPs) at a single actuarial value level of coverage, and States would not be given an opportunity to recommend that these options not be implemented in their State.

We also proposed adding new paragraph § 155.705(b)(3)(x) to provide that the employer choice models available through the FF–SHOP platform would be available for SBE–FPs utilizing the Federal platform for SHOP enrollment functions. We discussed how, if we gave States with FF–SHOPs an opportunity to recommend implementation of additional employer choice models, States with SBE–FPs would be given the same opportunity.

Additionally, we proposed to amend paragraph (b)(4)(ii)(B) to specify the timeline under which qualified employers in an FF–SHOP must make initial premium payments. We proposed to add paragraph (b)(4)(ii)(B)(*1*) to specify that in the FF–SHOPs, payment for the group's first month of coverage must be received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage begins. We explained that electronic payments would have to be completed or the premium aggregation services vendor must have receipt of any hard copy check on or before the 20th day of the month prior to the month that coverage would begin. We also explained that if an initial premium payment is not received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage would begin, coverage would not be effectuated. We further explained that grace period and reinstatement opportunities under § 155.735(c)(2), which are provided to groups that do not make timely payments after coverage has taken effect, are not relevant in this context, and we proposed amendments to introductory language at § 155.735(c)(2) to reflect this.

In circumstances where an FF–SHOP would be retroactively effectuating coverage for qualified employer groups, the FF–SHOP would need to receive payment prior to effectuating coverage. We sought comment on the timing of when a premium payment should be

required to be received by an FF–SHOP when coverage is effectuated retroactively, and explained that we were considering a policy under which payments for the first month's coverage and all months of the retroactive coverage would have to be received and processed no later than 30 days after the event that triggers the eligibility for retroactive coverage.

At paragraph (b)(4)(ii)(C)(*2*), we proposed to correct a cross reference to § 155.705(b)(4)(ii)(B)(*1*) that should have been updated to cross-reference § 155.705(b)(4)(ii)(C)(*1*) when paragraph (b)(4)(ii)(A) was added in the 2016 Payment Notice.

We also proposed amendments to § 155.705(b)(11)(ii) to provide for FF–SHOPs to use a ''fixed contribution methodology'' in addition to the reference plan methodology set forth in the current regulation. We proposed to specify that when an employer decides to offer a single plan to qualified employees, the employer would be required to use the fixed contribution methodology. We also proposed to permit employers to choose between the reference plan contribution methodology and the proposed fixed contribution methodology when offering a choice of plans. Additionally, we proposed to add language to § 155.705(b)(11)(ii) explaining that a tobacco surcharge, if applicable, would be added to the monthly premium after the employer contribution is applied to the premium. Finally, we proposed to streamline the discussion of the reference plan contribution methodology described in § 155.705(b)(11)(ii) and proposed removing § 155.705(b)(11)(ii)(D) because the FF–SHOPs are currently not able to support basing employer contributions on calculated composite premiums.

We are finalizing the provisions regarding the FF–SHOP's authority to provide vertical choice, but will provide States with FF–SHOPs an opportunity to recommend that the FF–SHOP in their State not offer vertical choice in their State. States with SBE–FPs utilizing the Federal platform for SHOP enrollment functions will have the authority to opt out of making vertical choice available in their States. Information about whether vertical choice will be available in specific States with an FF–SHOP or SBE–FP will be made public prior to the deadline for QHP certification application submissions for the applicable year. We are also making a minor modification to add ''stand alone dental'' to the first sentence of § 155.705(b)(3)(ix)(C).

Comment: We received several comments concerning the additional proposed employer choice options. Many commenters supported the additional employer choice options because they would enhance the appeal of FF–SHOPs for both employees and employers. One commenter encouraged HHS to expand its proposal by allowing FF–SHOP employees to select from a wider variety of plans. Some commenters did not support adding vertical choice as an additional employer choice option, expressing concern about adverse selection because vertical choice could lead smaller employer groups with enrollees in need of more medical services to enroll in higher metal level QHPs. Additionally, there is concern that even if vertical choice is available to employers, an employer could still select horizontal choice or a single plan causing adverse selection. Commenters recommended that HHS consider the impact on selection and resulting changes in plan pricing when considering offering vertical choice in an FF–SHOP. One commenter recommended that FF–SHOP members only be allowed to enroll in one plan with one carrier to reduce complexity in the FF–SHOPs. Some commenters recommended that HHS promote the existing employer choice options instead of adding new employer choice options at this time. Other commenters believed that additional changes to employer choice will create confusion, add complexity, and create administrative challenges which would discourage participation in FF–SHOPs. One commenter also expressed concern about employer choice options, stating that if employers are required to select a specific issuer to offer coverage to the group, provider networks for employees could potentially be disrupted. To address this, the commenter recommended that HHS open all QHPs to employees enrolling in coverage through an FF–SHOP.

Response: We are finalizing the proposal to provide for a vertical choice option in FF–SHOPs, for plan years beginning on or after January 1, 2017. We agree with commenters that additional employer choice options can enhance the appeal of the FF–SHOPs, and intend to work with stakeholders to minimize any confusion stemming from the introduction of vertical choice. Due to operational limitations, at this time we are not offering a wider variety of employer choice options. We appreciate the concerns raised about adverse selection, but believe the fact that our proposal limits vertical choice to a single issuer's plans will help allow the issuer to manage the risk of adverse selection. Offering multiple plans to a qualified employer group allows an issuer to enroll a greater share of the group than if multiple issuers offering coverage in a single coverage level were vying for members of the group. Issuers would thus likely enroll a more diverse risk pool from the qualified employer's group. While qualified employers may still choose to offer their qualified employees horizontal choice or a single plan, the availability of the additional vertical choice option may help to mitigate the risk for adverse selection. To mitigate concerns raised by commenters and because we believe States are best positioned to understand the small group market dynamic in their State, HHS will provide States with an FF–SHOP an opportunity to recommend that the FF–SHOP in their State not make vertical choice available in their State. For similar reasons, States with SBE–FPs utilizing the Federal platform for SHOP enrollment functions will be able to opt out of making vertical choice available in their States. In States where vertical choice is available, a qualified employer would have a choice of three employer choice options for both QHPs and SADPs: A single plan, all available plans at a single level of coverage (horizontal choice, as provided for by the statute), and a choice of all plans offered by a single issuer across all levels of coverage (vertical choice). In States where vertical choice is not an available option for qualified employers, the single plan option and horizontal choice option would continue to be available to qualified employers.

Comment: We received several comments supporting adding contiguous choice as an additional employer choice option because employers would have more QHP options available to offer to their employees. One commenter recommends that HHS consider the additional administrative costs of allowing additional choice options.

Response: As stated, we believe additional employer choice options could enhance the appeal of the FF–SHOPs, and we will continue to explore adding the option of contiguous choice in the future, but are not adding a contiguous choice option at this time, so that we can further consider the potential for adverse selection that could result from that option.

Comment: One commenter recommended that States should not be permitted to make the decision on whether to implement new approaches for employer choice in FF–SHOPs and that it should be at the issuer's option about which QHPs and SADPs to make available to qualified employees. The

commenter recommended that HHS require States to conduct an assessment on the actuarial impact of various employer choice approaches, and determine safeguards that will protect against adverse selection. Other commenters also stated they do not agree with allowing States to opt in and out of offering vertical choice, and supported standardizing employer choice options across all States that have an FF–SHOP or that rely on the Federal platform for SHOP enrollment. Another commenter encouraged HHS to only allow additional employer choice options in States where the same option currently exists in the off-Exchange market, to prevent possible adverse selection while promoting a stable small group market.

Response: In order to provide for State-specific evaluations of the impact of vertical choice on adverse selection and resulting changes in plan pricing, and to provide for more uniform small group market coverage options both on and off-Exchange, States with an FF–SHOP will be given an opportunity to recommend that the FF–SHOP in their State not offer vertical choice. States with SBE–FPs utilizing the Federal platform for SHOP enrollment functions will be able to opt out of making vertical choice available in their States. We believe that States are best positioned to assess the impact of additional employer choice options based on local market conditions. A State with an FF–SHOP that wishes to recommend against offering vertical choice in that State must submit a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS, describing and justifying the State's recommendation, based on the anticipated impact vertical choice would have on the small group market and consumers. A State-based Exchange utilizing the Federal platform for SHOP enrollment functions may decide against offering vertical choice by notifying HHS of that decision.

HHS is requiring that a State with an FF–SHOP that wishes to recommend against offering vertical choice in that State make its recommendation to the FF–SHOP by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers. This deadline will give issuers sufficient time to make informed decisions about whether to participate in the FF–SHOP, and will give the FF–SHOPs sufficient time to implement the State's recommendation. States with FF–SHOPs will be able to make recommendations regarding vertical choice on an annual basis. For plan years beginning in 2017 only, we strongly recommend that States with FF–SHOPs submit their recommendations to HHS on or before March 25, 2016, via email to *shop@cms.hhs.gov.* States that meet this deadline will provide the FF–SHOPs sufficient time to review and implement State recommendations. HHS anticipates that its decisions regarding State recommendations for plan years beginning in 2017 would be made by April 1, 2016, which would provide issuers with sufficient time to determine their involvement in the FF–SHOPs for the following year.

For these same reasons, we are finalizing our proposal to add a new paragraph at § 155.705(b)(3)(x) to provide that the employer choice models available through the FF–SHOP platform will be available for SBE–FPs utilizing the Federal platform for SHOP enrollment functions, except that SBE–FPs may decide against offering the employer choice models specified in paragraphs (b)(3)(viii)(C) and (b)(3)(ix)(C). Under the final rule, a State with an SBE–FP must notify HHS of its decision against offering vertical choice in that State in advance of the annual QHP certification application deadline, by a date to be established by HHS. Again, this deadline will give issuers sufficient time to make informed decisions about whether to participate in the SHOP, and will give us sufficient time to implement the State's decision. States with SBE–FPs will be able to make decisions regarding vertical choice on an annual basis. For plan years beginning in 2017 only, we strongly recommend that States with an SBE–FP utilizing the Federal platform for SHOP enrollment functions notify HHS of their decisions on or before March 25, 2016, via email to *shop@cms.hhs.gov.* Again, States that meet this deadline will provide the FF–SHOPs sufficient lead time to implement the State's decision. HHS anticipates that it will announce the SBE–FP States that have decided against offering vertical choice for plan years beginning in 2017 on or around April 1, 2016, which would provide issuers with sufficient time to decide whether to participate in the SHOP for the following year.

Additional guidance will be provided to States regarding the notification or recommendation time frames for plan years beginning in 2018 and beyond.

Comment: Some commenters believe that requiring employer groups to make initial premium payments by the 20th day of the month prior to the month that coverage begins increases the potential for issuers not to receive the initial premium payment until after the first month of effectuated coverage. These commenters recommended that issuers not be required to effectuate coverage without payment from the FF–SHOP.

Response: We are finalizing the provision with a modification to specify that a similar policy also applies under circumstances of retroactive coverage. Under § 156.285(c)(8)(iii), FF–SHOP issuers are required to effectuate coverage unless the FF–SHOP sends a cancellation notice prior to the coverage effective date. Section 156.285(c)(8)(iii) does not require issuers to effectuate coverage if the FF–SHOP does not receive a premium payment by the deadline established for the FF–SHOP. If payment is not received by the FF–SHOP prior to that deadline, the FF–SHOP will issue a cancellation notice.

We are finalizing the following premium payment policies for circumstances where an FF–SHOP would be retroactively effectuating coverage. These policies differ somewhat from the policies we explained we were considering in the preamble to the proposed rule, because for operational reasons, premium payments must be received by the FF–SHOP premium aggregation services vendor by a certain date in order to be processed in a timely manner. When coverage is effectuated retroactively, as discussed in the proposed rule preamble, payment for the first month's coverage and all months of the retroactive coverage must be received and processed no later than 30 days after the event that triggers the eligibility for retroactive coverage. Additionally, however, in order for coverage to be effectuated by the first day of the following month, the employer must also make this payment by the 20th day of the preceding month. If payment is made after the 20th day of a month, coverage will take effect as of the retroactive coverage effective date, but coverage will not be effectuated until the first day of the second month following the payment, and the payment must include the premium for the intervening month. Regardless, in order to effectuate retroactive coverage for a qualified employer or qualified employee, such as under an appeal decision, all premiums owed must be paid in full, including any prior premiums owed for coverage back to the retroactive coverage effective date, as well as a premium pre-payment for the next month's coverage.

These policies also apply to SBE–FPs that are utilizing the Federal platform

for SHOP enrollment and premium aggregation functions, because premium aggregation is an integral part of the eligibility and enrollment functions managed through the FF–SHOP platform.

Comment: We received a comment expressing concern that employer groups will not be able to make the full premium payment within 30 days after the event that triggers eligibility for retroactive coverage, depending on how many months of retroactivity are covered. The commenter recommended that issuers not be required to effectuate retroactive coverage without full payment.

Response: We believe that 30 days after the event that triggers eligibility for retroactive coverage is sufficient time for employer groups to make their full premium payment in order to have retroactive coverage. This policy also ensures that issuers receive payments in a timely manner. Issuers are not required to effectuate coverage if an employer's full payment is not received by the deadline set by the FF–SHOP. Issuers should not cancel an enrollment transaction unless the FF–SHOP sends a cancellation transaction.

Comment: We received no comments regarding our proposal to correct the cross reference from § 155.705(b)(4)(ii)(B)(*1*) to § 155.705(b)(4)(ii)(C)(*1*).

Response: We are finalizing this provision as proposed.

Comment: With respect to our proposals to amend § 155.705(b)(11)(ii), one commenter recommended that HHS clarify that any tobacco surcharge would be paid to the FF–SHOP and not to issuers separately. Another commenter recommended that the tobacco surcharges should be spread across the costs of coverage for an entire group, rather than for the tobacco users only.

Response: Any applicable tobacco surcharges will continue to be paid directly to the FF–SHOP as part of the group's total premium payment and will not be paid to issuers separately. We disagree that the tobacco surcharge should be spread across the entire group. The surcharge is a cost borne by the tobacco user and other enrollees in a group should not be responsible for sharing in its cost. We are finalizing the proposed amendments to § 155.705(b)(11)(ii) with a modification to the language about tobacco surcharges for clarity. We are also modifying the proposed language about the contribution methodologies available to employers that offer a choice of plans to replace a reference to ''the level of coverage offered'' with a reference to the ''plans offered,'' to reflect the possibility that employers might offer vertical choice under the amendments finalized in this rule.

Comment: With respect to our proposals to amend § 155.705(b)(11)(ii), we received one comment stating that if the FF–SHOP cannot support basing employer contributions on calculated composite premiums, employers may lose interest in participating in FF–SHOPs. Another commenter stated that because this feature is widely available off-Exchange, removing this option would put FF–SHOPs at a competitive disadvantage. Several commenters urged HHS to continue seeking feedback on this feature.

Response: Because of operational limitations, FF–SHOPs are not currently able to support basing employer contributions on calculated composite premiums. However, we appreciate the concerns expressed by commenters and we are therefore not finalizing the removal of this provision as proposed. Instead, we are modifying the provision at § 155.705(b)(11)(ii)(D) to state that an FF–SHOP may permit employers to base contributions on a calculated composite premium for employees, for adult dependents, and for dependents below age 21, which gives the FF–SHOPs the flexibility to implement this approach in the future. We are also removing the reference to ''the reference plan'' in this provision to reflect the availability of the fixed contribution methodology under the amendments finalized in this rule. We will continue to examine supporting employer contributions based on calculated composite premiums in the FF–SHOPs.

b. Eligibility Determination Process for SHOP (§ 155.715)

In order to align with our interpretation of guaranteed availability and guaranteed renewability, we proposed to specify that the termination described in § 155.715(g)(1) would be a termination of the employer group's enrollment through the SHOP, rather than a termination of a group's coverage. In many circumstances, an employer may offer to continue the same coverage outside of the SHOP, in which case the issuer should not terminate the coverage. We are finalizing this provision as proposed.

Comment: Some commenters support removing automatic terminations of SHOP coverage in order to be consistent with guaranteed renewability requirements. One commenter recommended that if an employer no longer has SHOP coverage, the employer should be able to make no contribution toward the cost of employee coverage through the SHOP. Employees would be responsible for paying the full premium amount. Another commenter stated that making the coverage available outside of the SHOP and requiring employers to make payments and send data directly to issuers will introduce complexity, undue burden, and unnecessary confusion due to the differing issuer and SHOP data and payment methods. We also received one comment recommending that HHS wait to implement terminations of SHOP enrollment, rather than a termination of the group's coverage, until the infrastructure exists to automate the process.

Response: In order to align with regulations around guaranteed availability and guaranteed renewability, we are finalizing the provision as proposed. Employers can decide whether to contribute toward the cost of employee coverage regardless of whether the employee has coverage through a SHOP. Employer groups wishing to maintain their small group coverage outside of a SHOP are encouraged to work directly with issuers to do so. If an employer offers coverage outside of a SHOP, enrollment and payment functions will be between the group and the specific issuer, and not through the SHOP. SHOPs are encouraged to work directly with issuers and groups to address any questions and concerns about the transfer of responsibility from the SHOP to the issuer. SHOPs, and not issuers, initiate all terminations of a group's enrollment through the SHOP, and this is how the FF–SHOP currently operationalizes terminations of group enrollments. FF–SHOPs are not able to automate the process of terminating FF–SHOP enrollment because it requires information from issuers and groups to ensure a transfer of responsibility should a group's coverage continue outside of the FF–SHOP.

c. Enrollment Periods Under SHOP (§ 155.725)

In § 155.725, we proposed to amend paragraph (c). Specifically, we proposed to delete paragraph (c)(1) because it is outdated, redesignate current paragraph (c)(2) as introductory text to paragraph (c), and redesignate the remaining paragraphs to reflect the new structure of paragraph (c).

We also proposed to redesignate § 155.725(e) as § 155.725(e)(1), and add paragraph (e)(2) to specify that qualified employers in the FF–SHOP must provide qualified employees with an annual open enrollment period of at least 1 week. Like all of § 155.725(e), this amendment would only apply to renewals of SHOP participation.

Additionally, we proposed amendments to § 155.725(h)(2) to specify that in the case of an initial group enrollment or renewal, the event that triggers the group's coverage effective date in an FF–SHOP is not the plan selection of an individual qualified employee being enrolled as part of the group enrollment, but the employer's submission of all plan selections for the group, which we refer to in rule text as the group enrollment. This amendment would permit qualified employers to set initial and annual enrollment periods for their qualified employees that could include qualified employee plan selections both before and after the 15th day of the month. We also proposed to permit employers to select a coverage effective date up to 2 months in advance, provided that small group market rates are available for the quarter in which the employer would like coverage to take effect. Under the proposal, if an employer submits its group enrollment by the 15th day of any month, the FF–SHOP would ensure a coverage effective date of the first day of the following month, unless the employer opts for a later effective date for which rates are available. If an employer submits its group enrollment between the 16th day of the month and the last day of the month, we proposed that the FF–SHOP ensure a coverage effective date of the first day of the second following month, unless the employer opts for a later effective date for which rates are available. We note that the effective date of coverage selected by a qualified employer remains subject to the limit on waiting periods under § 147.116.

We also proposed to amend § 155.725(i)(1) to provide that a SHOP be permitted to, but not be required to, provide for auto-renewals of qualified employees. We also proposed to amend the language of the provision for consistency with our interpretation of guaranteed renewability. Specifically, if a SHOP does not provide for auto-renewals for qualified employees, qualified employees would have to review and provide a response to the employer's renewal offer of coverage. If auto-renewal is available in a SHOP, qualified employees would not be required to take any action to continue in the prior year's coverage through the SHOP.

Finally, we proposed to amend § 155.725(j)(2)(i) to remove a reference to § 155.420(d)(10), which was deleted in the 2016 Payment Notice. We also proposed to specify that there would not be a SHOP special enrollment period when a qualified employee or dependent of a qualified employee experiences an event described in § 155.420(d)(1)(ii), which provides for a special enrollment period for individuals enrolled in a non-calendar year group health plan or individual health insurance coverage.

We are finalizing these amendments as proposed.

Comment: We received several comments about the length of a qualified employee's annual open enrollment period for renewals. Some commenters stated they believe the proposed minimum annual open enrollment period of one week is insufficient. One commenter recommended that employees be provided with a 30-day annual open enrollment period, or at a minimum, a two-week annual open enrollment period.

Response: The proposed amendment would not prevent a qualified employer from offering annual enrollment periods to qualified employees that are longer than one week. This regulation specifies only the minimum length of the annual open enrollment period for qualified employees. We are finalizing this provision as proposed because it would enable qualified employers and qualified employees, especially at very small companies, to finalize their annual renewal process more quickly.

Comment: We received one comment supporting our proposal to allow employers to opt for a coverage effective date up to 2 months in advance. The commenter stated that this amendment increases employer flexibility and may improve the consumer's experiences with SHOP.

Response: We are finalizing the provision as proposed. We note that the effective date of coverage selected by a qualified employer remains subject to the limit on waiting periods under § 147.116.

Comment: One commenter supported the proposed change to allow SHOPs to offer auto-renewals of qualified employees. However, another commenter did not support this automated process because of the risk of error.

Response: Auto-renewals provide a more streamlined, efficient way to renew coverage with minimal risk for error, and our rule will permit SHOPs to do so. We note that the FF–SHOPs are not able to support this feature at this time. Additional guidance will be provided if auto-renewal becomes available in the FF–SHOPs.

Comment: We received one comment supporting the proposal that there not be a SHOP special enrollment period when a qualified employee or dependent of a qualified employee is enrolled in a non-calendar year group health plan or individual health insurance coverage.

Response: We are finalizing the provision as proposed.

d. Termination of SHOP Enrollment or Coverage (§ 155.735)

To align with proposed amendments to § 155.705(b)(4), we proposed to modify the introductory language of § 155.735(c)(2) to specify that the provisions related to termination of employer group health coverage for non-payment of premiums in FF–SHOPs under paragraph (c)(2) do not apply to premium payments for the first month of coverage. We did not receive any comments regarding this proposal, and are finalizing it as proposed.

We also proposed amendments to § 155.735(d) to specify that if an enrollee changes from one QHP to another during the annual open enrollment period or during a special enrollment period, the last day of coverage would be the day before the effective date of coverage in the enrollee's new QHP.

Additionally, we proposed at § 155.735(d)(2)(iii) to require FF–SHOPs to send advance notices to qualified employees before their dependents age off of their plan. The notice would be sent 90 days in advance of the date when the child dependent enrollee is no longer eligible for coverage under the plan the employer purchased through the FF–SHOP because he or she has reached the maximum child dependent age for the plan. The notice would include information about the plan in which the dependent is currently enrolled, the date the dependent would age off the plan, and information about next steps. In the FF–SHOPs, a dependent aging off of the plan loses eligibility for dependent coverage at the end of the month of the dependent's 26th birthday or at the end of the month in which the issuer has set the maximum dependent age limit (but in some cases might have the option to keep the coverage for a period of time after that date under applicable continuation coverage laws). This notice is intended to be a courtesy notice as enrollees would still receive a termination notice when their coverage through the SHOP is terminating.

We are finalizing these provisions generally as proposed, with the exception of a technical correction to paragraph (d)(2)(ii) to replace the citation to § 155.420(b)(2) with a citation to § 155.725(j)(5), the SHOP rule under which SHOP enrollments are effectuated pursuant to special enrollment periods. Section

155.725(j)(5) cross-references § 155.420(b), and thus also cross-references the retroactivity possible under § 155.420(b)(2).

Comment: We received one comment supporting our proposal to send qualified employees 90 days advance notice of when a child dependent is no longer eligible for coverage under the plan the employer purchased through the FF–SHOP because he or she has reached the maximum child dependent age for the plan. The commenter notes that it is important to recognize that the age-off date may go well beyond a dependent's twenty-sixth birthday, depending on State dependent coverage laws.

Response: We are finalizing the provision as proposed. If a State or issuer sets maximum dependent age limits greater than 26 years, the FF–SHOPs will send the notice 90 days in advance of when the child dependent is no longer eligible for coverage under the plan the employer purchased through an FF–SHOP. The FF–SHOPs will be able to accommodate issuer-specific and State-specific maximum dependent age limits.

e. SHOP Employer and Employee Eligibility Appeals Requirements (§ 155.740)

In § 155.740, we proposed amendments relating to SHOP appeals. We proposed to provide that employers and employees may file an appeal not only if a SHOP fails to provide an eligibility determination in a timely manner, but also if a SHOP fails to provide timely notice of an eligibility determination. We also proposed to allow employers and employees who successfully appeal a denial of SHOP eligibility to select whether the effective date of coverage or enrollment through the SHOP under their appeal decision will be retroactive to the effective date of coverage or enrollment through the SHOP that the employer or employee would have had if they had correctly been determined eligible, or prospective from the first day of the month following the date of the notice of the appeal decision. Additionally, we proposed that if eligibility is denied under an appeal decision, the appeal decision would be effective on the first day of the month following the date of the notice of the appeal decision.

Comment: Some commenters said they believe that if an employer only adds eligible employees to the roster, then the SHOP will have no knowledge of ineligible employees. Therefore, the process of employees appealing to the SHOP will never be a valid scenario because no ineligibility notification will ever be sent by the SHOP to the employee. Another commenter suggested that HHS retain the current regulatory language about the coverage effective date after a successful appeal decision or adopt an effective date that is the first of the month following the appeal decision, but not allow each group to choose. Some commenters stated that only those who had retroactive claims would select the retroactive date. Commenters also recommended that coverage should never take effect more than a month retroactively, or that coverage should start immediately.

Response: We are finalizing as proposed our proposal that employers and employees may file an appeal not only if a SHOP fails to provide an eligibility determination in a timely manner, but also if a SHOP fails to provide timely notice of an eligibility determination. SHOPs may send a notice of ineligibility if the information provided by an employee does not match the information provided by the qualified employer. An FF–SHOP might send a notice of ineligibility to an employee, for example, if the employee inaccurately enters his or her unique participation code in the FF–SHOP employee application. We note that employers do not make SHOP eligibility determinations for employees. The SHOPs make all eligibility determinations for employees. Employers must offer SHOP coverage to all full-time employees; other employees and former employees added to the employee roster are also eligible for SHOP coverage.

We are making a minor modification to our proposal allowing employers and employees to select either a retroactive or prospective coverage or enrollment effective date if the appeal decision finds the employer or employee eligible, to specify that individual employees may select an effective date only when the appeal is of an individual employee's eligibility determination (rather than an appeal of a determination of eligibility for an employer, which affects coverage or enrollment for the entire group). We believe that if an employer or employee applied for coverage or enrollment with the intention that coverage would be effective on a specific date, received a denial of eligibility, and successfully appealed the decision, the employer or employee should be provided with the option to select retroactive or prospective coverage or enrollment, because the employer or employee was found to be eligible for SHOP coverage and the group or employee could have had SHOP coverage as early as the original desired date had the original eligibility determination been correct. Regardless of whether the group or employee has incurred claims, to provide maximum flexibility to consumers, we believe that the decision about whether to select a retroactive or prospective coverage or enrollment effective date should be the employer's or employee's. While we acknowledge issuers' concerns about who might select retroactive coverage, we note that retroactive coverage would be effectuated only if the requisite premium payment is made in accordance with § 155.705(b)(4)(ii)(B)(2), as finalized here. In the FF–SHOPs, premiums owed for employees that are found eligible under an employee appeal decision will be collected from employers as part of the next monthly invoice for the group.

We are finalizing § 155.740(l)(3)(iii), regarding the effective date of a denial of eligibility under an appeal decision, with a revision specifying that the appeal decision would be effective as of the date of the notice of the appeal decision. This is the same effective date that applies under the current version of § 155.740(l)(3), so there will not be any change in policy regarding the effective date of a denial of eligibility under an appeal decision under this rule. We have decided to maintain the current policy because if an employer or employee is denied eligibility and their appeal is also denied, the employer or employee might never have had enrollment or coverage through the SHOP, and even if they did, would not have been entitled to it. The SHOP should therefore be able to make the appeal decision effective as of the date of the notice of the appeal decision.

9. Exchange Functions: Certification of Qualified Health Plans

a. Certification Standards for QHPs (§ 155.1000)

(1) Denial of Certification

Section 1311(e)(1)(B) of the Affordable Care Act states that Exchanges may certify a health plan as a QHP if such health plan meets the requirements for certification as promulgated by the Secretary and the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers. Section 1311(e)(1)(B) thereby affords Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the interests of qualified individuals and qualified employers. In the proposed rule, we

stated that we interpret the ''interest'' standard to mean QHPs should provide quality coverage to consumers to meet the Affordable Care Act's goals.

Section 155.1000 provides Exchanges with broad discretion to certify health plans that otherwise meet the QHP certification standards specified in part 156. HHS expects to continue to certify the vast majority of plans that meet certification standards. HHS will focus denials of certification in the FFEs based on the ''interest of the qualified individuals and qualified employers'' standard on cases involving the integrity of the FFEs and the plans offered through them. Examples of issues that could result in non-certification of a plan include concerns related to an issuer's material non-compliance with applicable requirements, an issuer's financial insolvency, or data errors related to QHP applications and data submissions. Under this approach, HHS could consider an assessment of past performance, including with respect to oversight concerns raised through compliance reviews and consumer complaints received, and the frequency and extent of any data submission errors. In exercising this authority, HHS intends to adopt a measured approach that would take into consideration several factors, including available market competition and the availability of operational resources.

We noted that the Office of Personnel Management (OPM) has the sole discretion for contracting with multi-State plans and as such retains the authority to selectively contract with multi-State plans.

Comment: Several commenters opposed HHS's proposal to deny certification to plans based on the interest standard, stating ''additional'' or ''new'' HHS certification authority would reduce competition and innovation, lead to arbitrary, inconsistent, and capricious certification decisions, and interfere with State reviews. Other commenters agreed that HHS has existing authority to deny certification and supported the proposal. Those commenters believe that the use of such authority could promote the availability of high-value health plans and innovative health care delivery system reforms, encourage insurers to minimize annual rate increases, and enable FFEs to become a ''trusted source of quality coverage for consumers.''

Response: The interest standard was previously codified in § 155.1000 (77 FR 18467); thus, we did not propose new or additional certification authority.

Comment: Some commenters stated HHS should work with plans to address concerns and meet certification requirements rather than denying certification, and denials should only be used when a health plan is financially impaired. They also recommended HHS make specific requirements and examples available for comment (for example, clarifying how consumer complaints would be used to assess past performance) before finalizing any criteria. Other commenters agreed that HHS should use factors outlined in the proposed rule, such as consumer complaints and past performance, as criteria for denying certification. Some States shared information on their models. Other commenters wanted HHS to take additional factors into account, such as a ''history of repeated or egregious violations'' of nondiscrimination standards and network adequacy requirements. Another commenter asked HHS to consider safe harbors for innovative plan designs that provide incentives to reduce the cost of health care to consumers while providing EHB and meeting or exceeding minimum value (MV).

Response: As stated above, while we have existing authority to deny certification based on the interest standard, we are not including any specific requirements or criteria in this final rule. HHS will continue to focus on cases involving the integrity of the FFEs and the plans offered through them, and, as discussed in the proposed rule, will consider factors such as an issuer's material non-compliance with applicable requirements, an issuer's financial insolvency, or data errors related to QHP applications and data submissions. We expect to continue to certify the vast majority of plans that meet certification standards.

G. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Standardized Options

In order to provide a new option that could further simplify the consumer plan selection process, we proposed six standardized options that issuers could choose to offer in the individual market FFEs in plan year 2017. At § 156.20, we proposed to define a standardized option as a QHP with a cost-sharing structure specified by HHS. Each standardized option consists of a fixed deductible; fixed annual limitation on cost-sharing; and fixed copayment or coinsurance for a key set of EHB that comprise a large percentage of the total allowable costs for an average enrollee (these are the EHB in the Actuarial Value Calculator with the addition of urgent care). We proposed one standardized option at each of the bronze, silver (and the three associated silver CSR plan variations), and gold levels of coverage. We proposed that an issuer could offer a standardized option at one or more levels of coverage, with the exception that if it offers a silver standardized option, it must also offer the three associated standardized silver CSR plan variations. We did not propose a standardized option at the platinum level of coverage since only a small proportion of QHP issuers in the FFEs offer platinum plans.

We proposed that an issuer could offer more than one plan for each standardized option within a service area, subject to the meaningful difference requirements defined at § 156.298. This could be accomplished, for example, if the issuer offers an HMO standardized option at a particular level of coverage as well as a PPO standardized option at the same level of coverage. We also proposed that issuers would retain the flexibility to offer an unlimited number of non-standardized plans and that we would not limit the total number of QHPs that may be sold through an FFE in a rating area or county, outside of any limitations under the meaningful difference and other applicable QHP certification requirements.

We encouraged issuers to offer at least one standardized option, particularly at the silver level of coverage (and the associated silver CSR plan variation levels). This would simplify the consumer shopping experience for the greatest number of FFE QHP enrollees, since silver plans are the most common and popular plans in terms of enrollment in the FFEs.

We designed the standardized options to be as similar as possible to the most popular (weighted by enrollment) QHPs in the 2015 FFEs in order to minimize market disruption and impact on premiums.

We proposed that standardized options have the four drug tiers currently utilized in our consumer-facing applications—generic, preferred brand, non-preferred brand, and specialty drug tiers—with the option for issuers to offer additional lower-cost tiers if desired, since slightly more than half (56 percent) of the proposed 2016 FFE QHPs had more than four drug tiers.

We proposed that standardized options have no more than one in-network provider tier since varying cost sharing by provider tier affects the actuarial value of a plan, making it difficult to standardize a cost-sharing

structure. Additionally, only 14 percent of FFE enrollees in 2015 were enrolled in QHPs with more than one in-network tier, and only 6 percent of enrollees were covered by an issuer that did not offer a single-tier plan in addition to a multi-tier plan in the same county.

We proposed that the standardized options would exempt from the deductible certain routine services, such as primary care, specialist visits (at the silver and gold metal levels), and generic drugs, to ensure that access to coverage translates into access to care for routine and chronic conditions and that enrollees receive some up-front value for their premium dollars. Among 2015 FFE QHPs, more than 85 percent of silver plan enrollees and more than 50 percent of bronze plan enrollees selected plans that cover certain services prior to application of the deductible. (The figure for gold plan enrollees was more than 90 percent. However, many gold plans have a $0 deductible, in which case, the concept of deductible-exempt services would not be meaningful.) Primary care and generic drugs are the services most likely to be covered without a deductible at all metal levels. Other services that are also likely to be covered prior to the deductible, particularly by silver and gold plans, include specialist visits and mental/behavioral health and substance use disorder outpatient services.

We proposed that the standardized options balance consumer preference for copayments over coinsurance with the potential impact on premiums. Research shows that consumers often prefer copayments to coinsurance because copayments are more transparent and make it easier for consumers to predict their out-of-pocket costs. On the other hand, setting fixed copayments on a national level for high-cost services could lead to disparate premium effects due to regional and issuer-specific cost differences, or it could lead to premium increases or require corresponding increases in other forms of cost sharing, if set too low.

To reduce operational complexity, we proposed to not vary the standardized options by State or by region. We proposed one set of standardized options for all FFEs, including those in which States perform plan management functions, recognizing that some States regulate the level of cost sharing applied to certain benefits, such as emergency room services and specialty drugs.

We noted that we would be conducting consumer testing to help us evaluate ways in which standardized options, when certified by an FFE, could be displayed on our consumer-facing plan comparison features in a manner that makes it easier for consumers to find and identify them, including distinguish them from non-standardized plans. We noted that we anticipate differentially displaying the standardized options to allow consumers to compare plans based on differences in price and quality rather than cost-sharing structure as well as providing information to explain the standardized options concept to consumers. We also noted that we are considering whether to require QHP issuers or web-brokers to differentially display standardized options when a non-FFE Web site is used to facilitate enrollment in an FFE.

We noted that multi-State plan issuers may use the standardized options, but that OPM, at its discretion, may design additional standardized options applicable only to multi-State plan issuers. We would not display the OPM-designed standardized options applicable only to multi-State plan issuers in a differential manner, however, in order to preserve consistency in the standardized options identified by HHS in the FFEs.

We are finalizing the HHS-specified standardized options, but as further described below, we are specifying some changes to the standardized options' cost sharing, including one technical correction. These changes remain consistent with the general features and principles of standardized options described in the preamble to the proposed rule. We will make any additional changes to the standardized options in future rulemaking. The plans finalized in this rule apply beginning with the 2017 plan year and until any future changes are finalized.

In addition, we are adding to § 155.205(b)(1) a new provision codifying the Exchange's authority to differentially display standardized options on our consumer-facing plan comparison and shopping tools. (How standardized options will be displayed will take into consideration the results of consumer testing, which is currently in process.) We do not intend to require QHP issuers or web-brokers to adhere to differential display requirements of standardized options when using a non-Exchange Web site to facilitate enrollment in a QHP through an Exchange at this time, but will consider whether we should propose such a standard in the future. Additionally, because the provision in § 155.205(b)(1) refers to standardized options, we will finalize the definition of standardized option at § 155.20, which specifies the definitions for part 155, instead of at § 156.20, which specifies definitions for part 156.

Overall, commenters were supportive of the specific standardized plan designs, but suggested some modifications. The proposed 2017 bronze standardized option closely resembled a catastrophic plan, with a $6,650 deductible, an annual limitation on cost sharing equal to the maximum allowable annual limitation on cost sharing for 2017 (proposed to be $7,150), and 50 percent coinsurance for most types of benefits. Primary care visits (for the first three visits) and mental health/substance use outpatient services were exempt from the deductible with a copayment of $45. Generic drugs were also exempt from the deductible with a copayment of $35. The top three drug tiers each had a 50 percent coinsurance rate. We are making a change to the cost sharing for each of the top three drug tiers in the bronze standardized option. In response to commenters who noted the relative paucity of bronze plans on the FFEs with 50 percent coinsurance rates for drugs, the preferred brand drug tier now has a 35 percent coinsurance; the non-preferred brand drug tier now has a 40 percent coinsurance; and the specialty drug tier now has a 45 percent coinsurance. We are also making a technical correction to the Bronze plan's AV calculation to ensure that the deductible and coinsurance apply correctly after the first three primary care visits, to align with the Final 2017 AV Calculator User Guide instructions. Making this technical correction and the above changes to drug coinsurance rates raises the AV for the plan to 61.88. Thus, the AV for the final bronze standardized option is 0.06 percent higher than the AV of the proposed bronze standardized option, which was 61.82 (rounded to 61.8). The coinsurance rate for each of the top three drug tiers more closely reflects the average coinsurance rate for each of the top three drug tiers in the most popular (weighted by enrollment) QHPs in the 2015 FFEs, which were 25 percent, 35 percent, and 45 percent, respectively. The new bronze standardized option also addresses commenters' concerns that the proposed design was inconsistent with the principle of having four different drug tiers. Non-generic drugs would all have had a 50 percent coinsurance rate with the proposed version of the bronze standardized option.

The proposed 2017 silver standardized option had a $3,500 deductible, an annual limitation on cost sharing equal to the maximum allowable annual limitation on sharing

for 2017, and a 20 percent enrollee coinsurance rate. Primary care visits, mental health/substance use outpatient services, specialist visits, urgent care visits, and all drug benefits were exempt from the deductible, and all of the deductible-exempt benefits had copayments instead of coinsurance, except for the specialty drugs tier, which had a 40 percent coinsurance rate. Emergency room services were subject to the deductible, with a $400 copayment applicable after the deductible.

In the final rule, we are making a change to the proposed silver standardized option in response to comments. The proposed silver standardized option and gold standardized option had the same copayment value for generic drugs. We are increasing the copayment for generic drugs to $15 for the silver standardized option to more closely reflect the average copayment rate for generic drugs in the most popular QHPs in the 2015 FFEs (weighted by enrollment). The actuarial value of the new standardized silver option is 70.63 percent (0.37 percent lower than the AV of the proposed version).

The proposed silver cost-sharing reduction standardized options reduced all cost sharing parameters successively to meet the 73 percent, 87 percent, and 94 percent AV requirements. Where possible, the cost-sharing reduction standardized options and the non-cost-sharing reduction standardized silver option maintain similar differentials between the cost sharing for certain benefits like primary care and specialty visits. We are finalizing the three standardized options at the silver cost-sharing reduction variation levels.

The proposed 2017 gold standardized option, which we are also finalizing as proposed, has a $1,250 deductible, a $4,750 annual limitation on cost sharing, and a 20 percent coinsurance rate for most types of benefits. Primary care visits, mental health and substance use outpatient services, specialist visits, urgent care visits, and all drug benefits are not subject to the deductible. All of the benefits not subject to the deductible have copayments except for specialty drugs.

TABLE 9—FINAL 2017 STANDARDIZED OPTIONS

	Bronze	Silver	Silver 73% actuarial value variation	Silver 87% actuarial value variation	Silver 94% actuarial value variation	Gold
Actuarial Value (%)	61.88	70.63	73.55	87.47	94.30	79.98.
Deductible	$6,650	$3,500	$3,000	$700	$250	$1,250.
Annual Limitation on Cost Sharing.	$7,150	$7,150	$5,700	$2,000	$1,250	$4,750.
Emergency Room Services.	50%	$400 (copay applies only after deductible).	$300 (copay applies only after deductible).	$150 (copay applies only after deductible).	$100 (copay applies only after deductible).	$250 (copay applies only after deductible).
Urgent Care	50%	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$65 (*).
Inpatient Hospital Services.	50%	20%	20%	20%	5%	20%.
Primary Care Visit	$45 (* first 3 visits, then subject to deductible and 50% coinsurance).	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Specialist Visit	50%	$65 (*)	$65 (*)	$25 (*)	$15 (*)	$50 (*).
Mental Health/Substance Use Disorder Outpatient Services.	$45 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*).
Imaging (CT/PET Scans, MRIs).	50%	20%	20%	20%	5%	20%.
Rehabilitative Speech Therapy.	50%	20%	20%	20%	5%	20%.
Rehabilitative OT/PT.	50%	20%	20%	20%	5%	20%.
Laboratory Services	50%	20%	20%	20%	5%	20%.
X-rays	50%	20%	20%	20%	5%	20%.
Skilled Nursing Facility.	50%	20%	20%	20%	5%	20%.
Outpatient Facility Fee.	50%	20%	20%	20%	5%	20%.
Outpatient Surgery Physician/Surgical.	50%	20%	20%	20%	5%	20%.
Generic Drugs	$35 (*)	$15 (*)	$10 (*)	$5 (*)	$3 (*)	$10 (*).
Preferred Brand Drugs.	35%	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$30 (*).
Non-Preferred Brand Drugs.	40%	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*).
Specialty Drugs	45%	40% (*)	40% (*)	30% (*)	25% (*)	30% (*).

(*) = not subject to the deductible.

Comment: Many commenters supported our proposal to establish standardized options in the individual market FFEs in plan year 2017, as a step towards simplifying the consumer experience, both when shopping for

health insurance and when making cost-sharing payments to use covered health care services. Some commenters opposed our standardized options proposal, arguing that it will hamper innovation and limit competition and choice, and that differential or preferential display of standardized options could inadvertently steer consumers with specific or special health care needs towards selecting standardized options that are designed for the average QHP enrollee and not for a specific population. These commenters expressed their concern that our proposal represents a first step toward ultimately limiting or excluding non-standardized plans. These commenters stated that making standardized options mandatory in the future could stifle innovation in plan design, including value based insurance design offerings, as well as competition in the case that standardized options are sorted above non-standardized plans on our consumer-facing plan comparison and shopping tools. Among those who supported the standardized options proposal, many urged that offering them should be mandatory, even in 2017.

Response: We believe that standardized options can simplify the consumer shopping experience and are therefore finalizing the proposal for issuers to be able to offer standardized options if they choose. We recognize that these cost-sharing structures may not be appropriate for all issuers or all markets. We are not requiring issuers to offer standardized options, nor limiting their ability to offer other QHPs, and as a result, we do not believe that standardized options will hamper innovation or limit choice. Additionally, we will seek to mitigate the risk that consumers with special health care coverage needs incorrectly choose a standardized option through the use of tools that explain to consumers which cost-sharing features are standardized, and how they may differ from one another and from non-standardized plans, as well as how they can be used to simplify the shopping experience. We believe that most consumers with specialized health care needs will carefully shop for coverage that provides the right mix of cost-sharing protections, benefits, and networks.

Comment: Several commenters agreed with the features of our proposed standardized options, including the inclusion of certain deductible-exempt services, a single in-network provider tier, four drug tiers with the option of lower-cost tiers, and copayments in place of coinsurance where possible. We also received many recommended specific changes to the standardized option designs, particularly with respect to prescription drugs. Some commenters opposed the use of coinsurance for the specialty drug tier across all metal levels without the inclusion of specific and reasonable dollar level caps. Some commenters noted that the proposed bronze standardized option in effect has only two tiers, since the generic drug tier has a proposed copayment of $35 while the top three drug tiers all have the same coinsurance rate of 50 percent. Some commenters noted that the proposed copayments for generic drugs were set at the same copayment rate ($10) for both the gold standardized option and the silver standardized option and recommended that the generic copayment be lower in the gold plan than in the silver plan. Some commenters asked that all four drug tiers be exempt from the deductible, while others asked that drugs be subject to a separate deductible. Some commenters asked that we clarify that the copayment amounts for the drug tiers are for thirty-day retail fills. Some commenters asked that we clarify that issuers are permitted to create lower cost tiers for any of the four drug tiers, not just for the generic drugs tier. For example, commenters suggested that issuers should be permitted to create a preferred specialty tier with lower cost sharing than the specialty tier. Some commenters ask that we clarify that preferred and non-preferred pharmacies are permitted with differential cost sharing and that differential cost sharing is permitted for mail-service and retail pharmacies, such that the standardized cost sharing could represent cost sharing at non-preferred retail pharmacies, with lower cost sharing available at preferred retail or mail-service pharmacies.

Response: We are finalizing the standardized options as proposed except for the changes to the bronze and silver standardized options discussed above and the following clarifications. We clarify that that copayment amounts listed for the drug tiers are for thirty-day prescription fills at retail pharmacies and that issuers (or their prescription benefit managers) may offer a lower cost-sharing rate for mail order prescription fills, as is the most common practice in the current market. We also clarify that issuers may create a lower cost tier for the generic drugs tier for standardized options, but may not do so for the three higher drug tiers in the standardized options.

Comment: One commenter recommended that we create standardized options for family plans in addition to individual plans.

Response: We clarify that issuers may offer the standardized options as family plans by doubling the maximum annual limitation on cost-sharing and setting the family (other than self-only) deductible at twice the deductible provided here.

Comment: Some commenters urged that we exempt habilitative and rehabilitative outpatient services from the deductible in the standardized options. Some commenters also encouraged the creation of a standardized platinum option. Some commenters opposed designing the standardized options to be as similar as possible to the 2015 QHPs, noting that in their opinion, the 2015 QHPs often did not meet the needs of people with chronic conditions.

Response: We designed the plans to be as similar as possible to the 2015 QHPs (as measured on an enrollment-weighted basis) in order to minimize disruption to the market and impact on premiums. Only a minority of these plans exempted habilitative and rehabilitative outpatient services from the deductible. We will consider more deductible exempt services in future years depending on changes in the QHP markets, enrollment patterns, and other considerations.

Comment: Several commenters expressed concern with our proposal to establish a set of standardized options that would apply in all States in which an FFE is currently operating, noting that States may have established or may wish to establish their own standardized plans specific to their State-wide markets.

Response: As we note in the preamble to § 156.350 in this final rule, it is not possible at this time for the Federal platform to accommodate State customization, such as State-specific display elements on Plan Compare. State-defined standardized plans that are different from HHS's standardized options will not be displayed in the same manner as HHS's standardized options on the Federal platform because of the limitations described above.

Further, in a State that has required standardization of certain cost-sharing features of its QHPs or is considering doing so in 2017 or beyond, issuers must comply with State law, which may mean that issuers in those States will be unable to offer some or all of the standardized options established through this rule-making. At this time, the FFEs will not be able to give differential display to QHPs that differ from the standardized options finalized in this final rule, even if the only differences are to comply with State

laws. We will consider whether we may be able to do so in the future, however.

Comment: HHS solicited comments on whether it should require QHP issuers or web-brokers to differentially display standardized options when using a non-Exchange Web site to facilitate enrollment in a QHP through the Exchange. Commenters voiced concerns that web-brokers already have to comply with existing plan display requirements, such as displaying all plans sold on the Exchange, and not displaying plans based on compensation, and that should HHS adopt this policy, web brokers would need clear guidance and sufficient time to prepare.

Response: We recognize that currently, web-brokers are expected to comply with display requirements under § 155.220(c)(3), which includes disclosing and displaying all QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of § 155.205(b)(1) and (c), providing consumers the ability to view all QHPs offered through the Exchange, and displaying all QHP data provided by the Exchange. We are not requiring QHP issuers or web-brokers to adhere to differential display requirements of standardized options when using a non-Exchange Web site to facilitate enrollment in a QHP through an Exchange at this time. We will consider whether such a standard should apply to non-Exchange Web sites in the future. Web-brokers and issuers should continue to comply with all existing plan display requirements.

2. FFE User Fee for the 2017 Benefit Year (§ 156.50)

Section 1311(d)(5)(A) of the Affordable Care Act permits an Exchange to charge assessments or user fees on participating health insurance issuers as a means of generating funding to support its operations. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. If a State does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the Affordable Care Act directs HHS to operate an Exchange within the State. Accordingly, at § 156.50(c), we specify that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month that is equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for FFEs for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. As in benefit years 2014 to 2016, issuers seeking to participate in an FFE in benefit year 2017 will receive two special benefits not available to the general public: (1) The certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP. These special benefits are provided to participating issuers through the following Federal activities in connection with the operation of FFEs:

- Provision of consumer assistance tools.
- Consumer outreach and education.
- Management of a Navigator program.
- Regulation of agents and brokers.
- Eligibility determinations.
- Enrollment processes.
- Certification processes for QHPs (including ongoing compliance verification, recertification and decertification).
- Administration of a SHOP Exchange. Activities performed by the Federal government that do not provide issuers participating in an FFE with a special benefit will not be covered by this user fee.

OMB Circular No. A–25R further states that user fee charges should generally be set at a level so that they are sufficient to recover the full cost to the Federal government of providing the service when the government is acting in its capacity as sovereign (as is the case when HHS operates an FFE). Accordingly, we proposed to set the 2017 user fee rate for all participating FFE issuers at 3.5 percent. This user fee rate assessed on FFE issuers is the same as the 2014 to 2016 user fee rate. We are finalizing the 2017 user fee rate for all participating FFE issuers as proposed. In addition, OMB Circular No. A–25R requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. An exception was in place for the 2014 to 2016 user fee rates, to ensure that FFEs could support the goals of the Affordable Care Act, including improving the health of the population, reducing health care costs, and providing access to health coverage. We have sought an exception to this policy again for 2017.

Comment: Some commenters requested conversion of the FFE user fee assessment from percent of premium to a per member per month amount to decouple the user fee from medical inflation. We received one comment asking whether the user fees collected in 2017 will exceed the costs of the FFE. We also received comments stating that the user fee rate is likely too low to cover the full costs of the FFE.

Response: We will continue to assess the FFE user fee as a percent of the monthly premium charged by issuers participating in an FFE, in particular as it relates to the adequacy of funding for ongoing marketing and outreach. In accordance with OMB Circular No. A–25R, issuers are charged the user fee in exchange for receiving special benefits beyond those that are offered to the general public. Setting the user fee as a percent of premium ensures that the user fee generally aligns with the business generated by the issuer as a result of participation in an FFE. Additionally, the user fee rate is set to collect costs incurred for the special benefits, no more or less, and user fee collections are used solely to support FFE user fee eligible functions.

Additionally, we proposed under §§ 155.106(c) and 155.200(f) to allow State Exchanges to enter into a Federal platform agreement with HHS so that the State Exchange may rely on the Federal platform for certain Exchange functions to enhance efficiency and coordination between State and Federal programs, and to leverage the systems established by the FFE to perform certain Exchange functions. We proposed in § 156.50(c)(2) to charge SBE–FP issuers a user fee for the services and benefits provided to the issuers by HHS. For 2017, these functions will include the Federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs, as defined at section 1413(e) of the Affordable Care Act and enrollment in QHPs under § 155.400. As previously discussed, OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. We are finalizing our proposals under § 155.106(c) and § 155.200(f), and issuers seeking to participate in an SBE–FP in benefit year 2017 and beyond will receive special benefits not available to the general public: The ability to sell health insurance coverage through a State Exchange that realizes efficiencies by using the Federal platform to enroll

individuals determined eligible for enrollment in a QHP, including individuals who may be eligible for insurance affordability programs that may support premiums paid to issuers offering plans through the State Exchange by way of the Federal platform (HealthCare.gov), and the ability to sell health insurance coverage to small employers eligible to purchase QHPs for its employees through a SHOP Exchange. Other services that will be provided to issuers offering plans through an SBE–FP include the Federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs. We proposed to charge issuers offering QHPs through an SBE–FP a user fee rate of 3.0 percent of the monthly premium charged by the issuer for each policy under a plan offered through an SBE–FP. This fee would recover funding to support FFE operations incurred by the Federal government associated with providing the services described above.

The proposed user fee rate was calculated based on the proportion of FFE costs that are associated with the FFE information technology infrastructure, the consumer call center, and eligibility and enrollment services, and allocating a share of those costs to issuers in the relevant SBE–FPs. A significant portion of expenditures for FFE services are associated with the information technology, call center infrastructure, and personnel who conduct eligibility determinations for enrollment in QHPs and other applicable State health subsidy programs as defined at section 1413(e) of the Affordable Care Act, and who perform the functions set forth in § 155.400 to facilitate enrollment in QHPs. We intend to review the costs incurred to provide these special benefits each year, and revise the user fee rate for issuers in SBE–FPs accordingly in the annual HHS notice of benefit and payment parameters.

Comment: Commenters requested a one-year delay in assessing the user fee on issuers operating in an SBE–FP or a reduction of the user fee for 2017, particularly noting that SBE–FPs require additional time to integrate the user fee into their State's budget, and also that the impact of this user fee on premiums in SBE–FP States will be significant. Commenters also noted charging SBE–FP issuers the full user fee rate would allow the State to make a fully informed decision on the type of model to use for 2017. We also have received questions as to why we have not charged the SBE–FP user fees until now.

Response: While a user fee rate of 3.0 percent reflects HHS's actual costs, we recognize that State Exchanges that are currently using the Federal platform may find the abrupt change of the proposed user fee in 2017 challenging for their health insurance markets. Therefore, for the 2017 benefit year, we have sought a waiver from OMB to the requirement that the user fee with respect to SBE–FPs cover the full share of costs incurred by the FFE for providing these services, and, if we receive this waiver, would reduce the user fee rate by one-half for the issuers in an SBE–FP, to provide these States additional transition time to support the costs incurred by the FFE. That is, for the 2017 benefit year, issuers operating in an SBE–FP will be charged an amount equal to 1.5 percent of premiums in the SBE–FP.

We expect, in future rulemaking, to propose that SBE–FP issuers would be charged the full user fee rate covering the full share of costs incurred by the Federal platform for the special benefits provided to issuers in SBE–FPs. We note that we did not immediately assess a user fee on SBE–FP issuers because we did not establish our authority and intent to do so through rulemaking in time for rate-setting. We are drawing on our experience with SBE–FP operations in the 2014 and 2015 benefit years to establish a regulatory structure for SBE–FPs and to help determine an appropriate cost estimate for the SBE–FP user fee. As was the case with the FFEs, the user fee will not fully capture our costs, so that we can ease the transition for States and their issuers to adapt to these higher fees. We note that we similarly sought a waiver from OMB from the requirement that FFE user fees fully account for costs in the early years of the FFEs.

Comment: Some commenters requested that HHS implement the user fee in SBE–FP States by invoicing the State directly for the costs incurred or setting up a different methodology for recouping the costs incurred. These commenters indicated that a State that wishes to fund its Exchange operations by assessing a fee on all insurance carriers selling individual market major medical policies, both on and off Exchange, the Federal user fee structure would require the SBE–FP to execute a complex reconciliation process.

Response: We will assess the user fee rate as a percent of monthly premiums charged by issuers operating in an SBE–FP, as established in prior rulemaking. Setting the user fee as a percent of premium charged by issuers ensures that the user fee generally aligns with the business generated by the issuer as a result of the special benefits provided. We recognize that SBE–FPs may have elected to cover Exchange costs differently. Therefore, at an SBE–FP's written request, HHS will collect from the SBE–FP the total amount that would result from the user fee collected from issuers based on the percent of monthly premiums charged by invoicing the State for the total user fee charge, and not by collecting the fee directly from SBE–FP issuers.

Comment: One commenter requested unbundling of the costs of the Federal platform, as States may not utilize all aspects of the Federal platform bundle. We also received comments urging HHS to set a limit on the State's portion of the assessment for covering the State's costs. Commenters' suggestions for the user fee limit ranged from 3.5 percent to 5 percent of premiums for combined Federal and State user fee charges.

Response: As we discuss in § 155.106, HHS will not—at this time—offer a menu of Federal services from which an SBE–FP may select some but not other services on the Federal platform. As such, we are finalizing the SBE–FP user fee eligible costs as a bundle as proposed, and do not at this time anticipate unbundling the costs for each Federal service. We will also continue assessing the user fee by market. This means that, if an SBE–FP is not utilizing Federal services for the SHOP Exchange, the user fee would not be charged on SHOP issuers. Additionally, we do recognize the benefits of States operating their own plan management and customer support functions, and do not intend to limit the State's ability to generate revenue to support these functions.

Comment: One commenter sought confirmation that if a State is currently developing its own SBE platform, but later decides instead to rely on the Federal platform under the SBE–FP model, the SBE–FP model would be available to the State. Additionally, the commenter requested that in such a situation the State be charged the same user fee as charged to existing SBE–FPs.

Response: The SBE–FP model option will be available per the timelines and conditions we describe in § 155.106. The SBE–FP user fee for a particular benefit year, established through rulemaking, will apply to all States that use the SBE–FP for that benefit year, including those States that do not currently use the SBE–FP model. All issuers on SBE–FPs for the 2017 benefit year would receive the reduced 1.5 percent transitional rate. Additionally, we note that nothing restricts a State

from using its own revenue to support developing its own SBE platform.

Comment: Other commenters stated that the FFE and SBE–FP user fee rates are likely too low to provide all of the necessary functions for consumers, and that the assumption that FFE spend only 15 percent of user fee collections on marketing, outreach, and plan management is too low.

Response: Our current user fee rates for issuers in an FFE and an SBE–FP are based on our current anticipated contract costs for providing the special benefits. Our cost distributions are based on larger estimated enrollment through FFEs, and are not comparable to what individual States may spend on these functions. Further, to ensure FFEs can support many of the goals of the Affordable Care Act, we continuously assess our operational strategy for FFE functions to maximize access to health insurance coverage, and could seek, through notice and comment rulemaking, to change the user fee rate in future years to accommodate increased or decreased spending on areas such as marketing and consumer outreach.

Additionally, to ease administrative burdens on issuers and States, HHS proposed to offer States the option to have HHS collect an additional user fee from issuers at a rate specified by the State to cover costs incurred by the State-based Exchange for the functions the State retains. HHS would undertake this collection under the Intergovernmental Cooperation Act of 1968 (IGCA) if a written request is made by a State. If HHS agrees to provide such services, States may be required to reimburse HHS any additional costs that are associated with HHS's provision of such service. This coordination between the State and Federal programs would reduce administrative burden on issuers as well as the SBEs–FP. We did not receive any comments on this proposal for HHS to collect an additional user fee from issuers on behalf of the State. We will provide additional guidance if we receive such a request.

3. Single Risk Pool (§ 156.80)

We proposed to codify that any new rates set by an issuer in the small group market as part of a quarterly rate change would apply for new or renewing coverage on or after the rate effective date, and would apply for the entire the plan year. This policy is consistent with the preamble to the second Program Integrity Rule (78 FR 65067). We also proposed to make non-substantive changes to the wording of that paragraph, including to delete an outdated reference to when quarterly rate changes could first be implemented.

We also reiterated that a health insurance issuer may vary the plan-adjusted index rate for a particular plan from its market-wide index rate adjusting only for the explicitly stated factors in § 156.80(d)(2). Any plan level adjustment not specifically stated, including adjusting for morbidity of plan enrollees, is not permissible.

We received no comments on these specific issues and are finalizing the provisions as proposed.

4. Essential Health Benefits Package

a. Provision of EHB (§ 156.115)

In the 2016 final Payment Notice, we finalized regulation text at § 156.115(a)(5) that discussed habilitative services and devices. Due to a technical error in the amendatory instructions, the current CFR does not reflect this finalized language, and instead retains the language that was finalized prior to being amended by the 2016 Payment Notice; therefore, we are including regulation text in this rulemaking to make a technical correction to update the CFR to language that was previously finalized.

b. Prescription Drug Benefits (§ 156.122)

In the proposed rule, we discussed three proposals related to prescription drug benefits. First, § 156.122(c) requires plans providing EHB to have processes in place that allow an enrollee, an enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request and gain access to clinically appropriate drugs not covered by the plan. Such procedures must include a process to request an expedited review based on exigent circumstances meeting the requirements under § 156.122(c)(2). For plan years beginning in 2016 and thereafter, these processes must also include certain processes and timeframes for the standard review process, and have an external review process if the internal review request is denied. The costs of the non-formulary drug provided through the exceptions process must count towards the annual limitation on cost sharing and AV of the plan. As discussed in the 2016 Payment Notice (80 FR 10750), the exceptions process established in this section is distinct from the coverage appeals process established under § 147.136. Specifically, the drug exceptions process applies to drugs that are not included on the plan's formulary drug list, while the coverage appeals regulations apply if an enrollee receives an adverse benefit determination for a drug that is included on the plan's formulary drug list. Because these two processes serve different purposes, we reaffirmed our belief that they are not duplicative and we did not propose to change these definitions. However, we also clarified in the 2016 Payment Notice that ''nothing under this policy (§ 156.122(c)) precludes a State from requiring stricter standards in this area.'' We stated in the proposed rule that we received additional comment regarding States' coverage appeals laws and regulations and non-formulary drugs. In our discussion, we noted that if a State is subjecting non-formulary drugs to the standards under § 147.136 as opposed to § 156.122(c), the State's coverage appeals laws or regulations would provide the enrollee with a different process for review, and as a result a different process for obtaining coverage of the non-formulary drug. Specifically, § 147.136 has separate requirements for its external review process and allows for a secondary level of internal review before the final internal review determination for group plans.

As a result, if the State is subjecting non-formulary drugs to § 147.136 and the health plans are also required to comply with § 156.122(c), the health plan may have to satisfy two standards for non-formulary drugs. Therefore, we proposed amending § 156.122(c) to establish that a plan, in a State that has coverage appeals laws or regulations that are more stringent than or are in conflict with our exceptions process under § 156.122(c), and that include reviews for non-formulary drugs, the health plan's exception process satisfies § 156.122(c) if it complies with the State's coverage appeals laws or regulations. The purpose of § 156.122(c) is to ensure that an enrollee has the ability to request and gain access to clinically appropriate drugs not covered by the plan. Regardless of whether a State's coverage appeals laws or regulations satisfy § 156.122(c) or if the health plan meets § 156.122(c) through its exception process, we would expect that an enrollee would retain the ability to request and gain access to clinically appropriate drugs not covered by the plan. Therefore, we solicited comments on the scope of application of State appeals laws or regulations that include determinations for non-formulary drugs for this purpose, especially under medical necessity provisions. We also sought comment as to whether these provisions would allow the enrollee the ability to request and gain access to clinically appropriate drugs not covered by the plan in all cases through a State's coverage appeals laws or regulations. As

the State generally is the primary enforcer of the EHB requirements, the State would determine whether its coverage appeals laws or regulations would satisfy § 156.122(c) and therefore, would allow the health plans in the State to defer to the States' coverage laws or regulations. We noted that we consider multi-State plans that comply with OPM's coverage appeals requirements to satisfy § 156.122(c). We considered codifying this interpretation.

Second, we proposed amending the process at § 156.122(c) to allow for a second level of internal review. For example, we considered using the same timelines as the first level of internal review, 72 hours for the standard review request and 24 hours for the expedited review request.

Lastly, we sought comment on whether the substance use disorder requirement under EHB needs additional clarification with regard to medication assisted treatment (MAT) for opioid addiction.

We are finalizing one provision under this final rule to allow a State to determine that the health plans in the State satisfy § 156.122(c) when the health plans are required to adopt an exceptions process under the State's coverage appeals laws and regulations that include review of non-formulary drugs, and the exceptions process contains requirements at least as stringent as those under § 156.122(c).

Comment: Some commenters supported allowing the State to determine that health plans in the State comply with § 156.122(c) by virtue of the State's coverage appeals laws and regulations applying to non-formulary drugs, as long as the health plans treat the denied formulary exception as an adverse coverage determination under § 147.136. These commenters believed that this proposal is within the State's scope and would avoid duplication and potential operational and financial burdens of having the two different external review processes. Other commenters stated that HHS should require States to prove that they have a stronger standard than that required by the exception process and wanted HHS to make the determination as to whether a State has a stronger standard. Commenters wanted to know what would make a State law ''in conflict with'' the Federal standard and wanted HHS to study the issue to define the problem. These commenters were generally concerned with the timeframe differences between §§ 156.122(c) and 147.136. Some commenters also wanted the State to certify that their laws comply with § 156.122(c), such as with a tool, and to make the determinations publically available. Similarly, commenters supported or had concerns with the OPM clarification with regard to satisfying § 156.122(c). Some commenters requested additional clarification as to whether drugs count towards the annual limitation on cost sharing, such as cases when a State's coverage appeals laws and regulations are applying to non-formulary drugs. Some commenters wanted clarification that this exceptions process is different from the preventive services' exceptions process. Other commenters submitted comments about other prescription drug related issues beyond the scope of the proposed rule.

Response: We are finalizing our proposal that a State may determine that health plans in the State satisfy the requirements of § 156.122(c) if the health plans have a process through the State's coverage appeals laws and regulations to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan under standards at least as stringent as the requirements at § 156.122(c). To meet this standard, the process must include an internal review, an external review, the ability to expedite the reviews, and timeframes that are the same as or shorter than timeframes established under paragraphs (c)(1)(ii) and (c)(2)(iii) of this paragraph. In the event that an exception request is granted under § 156.122(c)(4), the excepted drug(s) are treated as an EHB including counting any cost-sharing towards the plan's annual limitation on cost-sharing under § 156.130.

While we appreciate commenters' concerns about potential confusion if two processes apply, we do not believe that applying timeframes less stringent than those in the current § 156.122(c) would benefit enrollees. We understand that States may not be able to meet these timeframes under their current coverage appeals laws and regulations and that States may have to change their laws and regulations in order to align the timeframes under § 156.122(c), if the State wishes to use its current laws and regulations to streamline processes and create efficiencies. The State is not required to undertake this option. We also reaffirm that we consider multi-State plans that comply with OPM's coverage appeals requirements to satisfy § 156.122(c). Lastly, we note that the exceptions process under § 156.122(c) is separate from other exceptions process required under applicable Federal or State law. In particular, compliance with the exceptions process under § 156.122(c) does not constitute compliance with the exceptions process for contraceptive services as clarified in guidance under section 2713 of the PHS Act, both of which apply to non-grandfathered individual and small group market plans that are required to provide EHB.[54]

Comment: Some commenters supported a second level of internal review and noted that including two levels of internal review is consistent with current practices, improves administrative efficiency, and ensures enrollees obtain medically necessary medications as soon as possible. The commenters noted that having only one level of internal review means more enrollees will rely on the external review process, which is costly. Some commenters sought additional time for the second level of review. Other commenters opposed a second level of internal review altogether and were primarily concerned that the second level of review could delay access and could burden enrollees. Some commenters wanted evidence that the second level of review would help enrollees, since the health plan conducts the internal review, as opposed to a third party. Some commenters wanted clarification as to whether this revised rule would be effective for the 2016 plan year or apply with enforcement discretion. Other commenters were concerned that the rule would apply different standards in 2016 versus 2017 (one level of internal review versus two).

Response: We are not finalizing new requirements in this area. A health plan, at its election, may conduct a concurrent second internal review in the standard review process and the expedited review process within the timeframes established under § 156.122(c)(1) and (2), but the health plan is not required to do so. As discussed in the preamble of the 2016 Payment Notice (80 FR 10818), all of the timeframes begin when the health plan or its designee receives a request. An enrollee or the enrollee's prescribing physician (or other prescriber) should strive to submit a completed request; however, health plans should not fail to commence review if they have not yet received information that is not necessary to begin review. Therefore, we interpret § 156.122(c)'s reference to receipt of the request to mean that the health plan must begin the review following the receipt of information

[54] See the section entitled ''Coverage of Food and Drug Administration (FDA)-approved Contraceptives'' in FAQS about Affordable Care Act Implementation (PART XXVI), (May 11, 2015), available at *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.*

sufficient to begin the review. We note that the processes specified in § 156.122(c) are only required in connection with requesting and gaining access to clinically appropriate non-formulary drugs, and are not required in connection with utilization management processes for drugs on the plan's formulary drug list. We also note that § 156.122(c) only applies to non-grandfathered individual and small group market plans that are required to provide EHB under section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act, as well as to QHPs under §§ 156.200(b)(3) and 156.20. We will continue to monitor the implementation of the drug exceptions processes to determine whether further guidance on these processes is needed.

Comment: We received many comments supporting requiring coverage of medication assisted treatment for opioid addiction as an EHB. These comments cited cost effectiveness, clinical evidence, and inability to interchange MAT options in support of requiring that all MATs be covered as an EHB. Commenters noted a lack of covered providers and related services limiting access to appropriate MAT; a lack of and variation in coverage of specific types of treatments, such as methadone; utilization management practices for MAT as areas of concern and reasons to require coverage of MAT. Commenters also noted the lack of MAT coverage by certain new State base-benchmark plans, including explicit exclusions. Other commenters were not supportive of additional clarification on MAT coverage for substance use disorders or wanted to review a specific proposal for additional coverage, as MAT is required to be covered under certain United States Pharmacopeia (USP) categories and classes at § 156.122(a)(1). Commenters were also concerned about setting a precedent in which MAT coverage is treated differently from other EHB or drugs, noting that EHBs are required under the statute to be equal to the scope of benefits provided under a typical employer plan. Some commenters supported the use of Pharmacy & Therapeutics (P&T) Committees in making drug coverage determinations and stated they were concerned that any coverage requirements could restrict and impede P&T Committees' clinical judgment. Others commented that requiring MAT coverage could increase premiums.

Response: In October 2015, the President issued a Memorandum directing Federal Departments and Agencies to identify barriers to medication-assisted treatment for opioid use disorders and develop action plans to address these barriers. Both the EHB requirement and Federal mental health and substance use disorder parity requirements apply to QHP coverage of medications to treat opioid dependence. Because these requirements extend beyond QHPs, we anticipate issuing separate guidance with respect to MAT in the near future.

c. Premium Adjustment Percentage (§ 156.130)

Section 1302(c)(4) of the Affordable Care Act directs the Secretary to determine an annual premium adjustment percentage, which is used to set the rate of increase for three parameters detailed in the Affordable Care Act: the maximum annual limitation on cost sharing (defined at § 156.130(a)), the required contribution percentage by individuals for minimum essential coverage the Secretary may use to determine eligibility for hardship exemptions under section 5000A of the Code, and the assessable payment amounts under section 4980H(a) and (b) of the Code. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and that this percentage will be published annually in the HHS notice of benefit and payment parameters.

Under the methodology established in the 2015 Payment Notice and amended in the 2015 Market Standards Rule for estimating average per capita premium for purposes of calculating the premium adjustment percentage, the premium adjustment percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the NHEA, which is calculated by the Office of the Actuary. Accordingly, using the employer-sponsored insurance data, the premium adjustment percentage for 2017 is the percentage (if any) by which the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2016 ($6,076) exceeds the most recent NHEA projection of per enrollee employer-sponsored insurance premiums for 2013 ($5,365).[55] Using this formula, we proposed and are finalizing the premium adjustment percentage for 2017 at 13.25256291 percent. We note that the 2013 premium used for this calculation has been updated to reflect the latest NHEA data. We are also finalizing the following cost-sharing parameters for calendar year 2017 based on our finalized 2017 premium adjustment percentage.

Maximum Annual Limitation on Cost Sharing for Calendar Year 2017. Under § 156.130(a)(2), for the 2017 calendar year, cost sharing for self-only coverage may not exceed the dollar limit for calendar year 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage for 2017, and for other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded down to the next lowest multiple of 50. Using the premium adjustment percentage of 13.25256291 percent for 2017 we established above, and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage, which was published by the IRS on May 2, 2013,[56] we are finalizing the 2017 maximum annual limitation on cost sharing as proposed at $7,150 for self-only coverage and $14,300 for other than self-only coverage.

Comment: Two commenters said the annual rate of increase in the MOOP ($300 for individuals this year after a $250 increase last year, and $600 for other than self-only coverage this year on top of a $500 increase last year) is unsustainable and negatively affects enrollees' willingness to use prescription drugs, which in turn affects health outcomes. The commenters asked HHS to engage with stakeholders to develop an alternative methodology to calculate the maximum annual limitation on cost sharing.

Response: As discussed above, the maximum annual limitation on cost sharing is calculated based on the premium adjustment percentage for the

[55] See Projections of National Health Expenditures: Methodology and Model Specifications (Jul. 28, 2015), available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf;* Projections of National Health Expenditures: Methodology and Model Specification (Sept. 18, 2013), available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology2012.pdf;* and Table 17: Health Insurance Enrollment and Enrollment Growth Rates (Jul. 22, 2015), available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html* (located in the NHE Projections 2014–2024—Tables link). For additional information, see, also, National Health Expenditure Projections 2012–2022, available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf.*

[56] *See:* IRS, 26 CFR 601.602: Tax forms and instructions (May 2, 2013), available at *http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.*

benefit year. The methodology established in 2015 to calculate the premium adjustment percentage is based on a projection of annual increases in per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (estimated by the CMS Office of the Actuary). HHS believes it is the best available source of projected growth for premium given statutory requirements and interaction with other measurements. However, as discussed in the 2015 Notice of Benefits and Payment Parameters (79 FR 13802), HHS intends to review the methodology for calculating annual premium growth after the initial years of reform-driven changes to benefits and plan design, after the premium trend is more stable, and as data on premiums become available.

Comment: One commenter expressed concern over a growing gap between the Affordable Care Act's maximum annual limitation on cost sharing and the Internal Revenue Service's out-of-pocket limit for high deductible health plans (HDHPs) used with health savings accounts. (The 2016 HHS maximum out-of-pocket limitation for other than self-only coverage was $600 above the 2016 IRS out-of-pocket limit on high deductible health plans for other than self-only coverage.) The commenter also expressed concern that the IRS limit is not announced for some months after the HHS limit is known, leading issuers to price products conservatively, and higher than they might otherwise if the IRS limit had been known.

Response: HHS and IRS are bound by different statutory parameters when calculating annual out-of-pocket limits. HHS uses the premium adjustment percentage described above to adjust the maximum out-of-pocket limit, and the IRS uses the Consumer Price Index, a measure of inflation, to adjust its out-of-pocket limitation.

d. Reduced Maximum Annual Limitation on Cost Sharing (§ 156.130)

Sections 1402(a) through (c) of the Affordable Care Act direct issuers to reduce cost sharing for EHBs for eligible individuals enrolled in a silver level QHP. In the 2014 Payment Notice, we established standards related to the provision of these cost-sharing reductions. Specifically, in 45 CFR part 156, subpart E, we specified that QHP issuers must provide cost-sharing reductions by developing plan variations, which are separate cost-sharing structures for each eligibility category that change how the cost sharing required under the QHP is to be shared between the enrollee and the Federal government. At § 156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver plan variation has an annual limitation on cost sharing no greater than the applicable reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters. Although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the Affordable Care Act, section 1402(c)(1)(B)(ii) of the Affordable Care Act states that the Secretary may adjust the cost-sharing limits to ensure that the resulting limits do not cause the AVs of the health plans to exceed the levels specified in section 1402(c)(1)(B)(i) of the Affordable Care Act (that is, 73 percent, 87 percent, or 94 percent, depending on the income of the enrollee). Accordingly, we propose to use a method we established in the 2014 Payment Notice for determining the appropriate reductions in the maximum annual limitation on cost sharing for cost-sharing plan variations. As we proposed above, the 2017 maximum annual limitation on cost sharing would be $7,150 for self-only coverage and $14,300 for other than self-only group coverage. We analyzed the effect on AV of the reductions in the maximum annual limitation on cost sharing described in the statute to determine whether to adjust the reductions so that the AV of a silver plan variation will not exceed the AV specified in the statute. Below, we describe our analysis for the 2017 benefit year and our proposed results.

Consistent with our analysis in the 2014, 2015, and 2016 Payment Notices, we developed three test silver level QHPs, and analyzed the impact on AV of the reductions described in the Affordable Care Act to the estimated 2017 maximum annual limitation on cost sharing for self-only coverage ($7,150). The test plan designs are based on data collected for 2016 plan year QHP certification to ensure that they represent a range of plan designs that we expect issuers to offer at the silver level of coverage through the Exchanges. For 2017, the test silver level QHPs included a PPO with typical cost-sharing structure ($7,150 annual limitation on cost sharing, $2,175 deductible, and 20 percent in-network coinsurance rate), a PPO with a lower annual limitation on cost sharing ($4,800 annual limitation on cost sharing, $2,775 deductible, and 20 percent in-network coinsurance rate), and an HMO ($7,150 annual limitation on cost sharing, $3,000 deductible, 20 percent in-network coinsurance rate, and the following services with copayments that are not subject to the deductible or coinsurance: $500 inpatient stay per day, $350 emergency department visit, $25 primary care office visit, and $50 specialist office visit). All three test QHPs meet the AV requirements for silver level health plans.

We then entered these test plans into the proposed 2017 AV Calculator developed by HHS and observed how the reductions in the maximum annual limitation on cost sharing specified in the Affordable Care Act affected the AVs of the plans. We found that the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 100 and 150 percent of the Federal poverty line (FPL) (2/3 reduction in the maximum annual limitation on cost sharing), and 150 and 200 percent of the FPL (2/3 reduction), would not cause the AV of any of the model QHPs to exceed the statutorily specified AV level (94 and 87 percent, respectively). In contrast, the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 200 and 250 percent of FPL (1/2 reduction), would cause the AVs of two of the test QHPs to exceed the specified AV level of 73 percent. As a result, we proposed that the maximum annual limitation on cost sharing for enrollees in the 2017 benefit year with a household income between 200 and 250 percent of FPL be reduced by approximately 1/5, rather than 1/2. We further proposed that the maximum annual limitation on cost sharing for enrollees with a household income between 100 and 200 percent of the FPL be reduced by approximately 2/3, as specified in the statute, and as shown in Table 10. These proposed reductions in the maximum annual limitation on cost sharing should adequately account for unique plan designs that may not be captured by our three model QHPs. We also noted that selecting a reduction for the maximum annual limitation on cost sharing that is less than the reduction specified in the statute would not reduce the benefit afforded to enrollees in aggregate because QHP issuers are required to further reduce their annual limitation on cost sharing, or reduce other types of cost sharing, if the required reduction does not cause the AV of the QHP to meet the specified level. We did not receive comments on this proposal, and are finalizing the

reductions in the maximum annual limitation on cost sharing for 2017 as proposed.

We note that for 2017, as described in § 156.135(d), States are permitted to submit for approval by HHS State-specific data sets for use as the standard population to calculate AV. No State submitted a data set by the September 1 deadline.

TABLE 10—REDUCTIONS IN MAXIMUM ANNUAL LIMITATION ON COST SHARING FOR 2017

Eligibility category	Reduced maximum annual limitation on cost sharing for self-only coverage for 2017	Reduced maximum annual limitation on cost sharing for other than self-only coverage for 2017
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) (that is, 100–150 percent of FPL)	$2,350	$4,700
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(ii) (that is, 150–200 percent of FPL)	2,350	4,700
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(iii) (that is, 200–250 percent of FPL)	5,700	11,400

e. AV Calculation for Determining Level of Coverage (§ 156.135)

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act direct issuers of non-grandfathered health insurance in the individual and small group markets, including QHPs, to ensure that plans meet a level of coverage specified in section 1302(d)(1) of the Affordable Care Act and codified at § 156.140(b). On February 25, 2013, HHS published the EHB Rule (78 FR 12833), implementing section 1302(d) of the Affordable Care Act, which required that, to determine the level of coverage for a given metal tier level, the calculation of AV be based upon the provision of EHB to a standard population. Section 156.135(a) establishes that AV is generally to be calculated using the AV Calculator developed and made available by HHS for a given benefit year. In the 2015 Payment Notice (79 FR 13743), we established at § 156.135(g) provisions for updating the AV Calculator in future plan years and in the proposed rule, we proposed to amend those provisions to allow for additional flexibility in our approach and options for updating of the AV Calculator in the future.

Specifically, we proposed that HHS will update the AV Calculator annually for material changes that may include costs, plan designs, the standard population, developments in the function and operation of the AV Calculator and other actuarially relevant factors. Under the amended regulation, we will continue to make updates to the AV Calculator, as we have in previous years, including updates to the trend factor, algorithms changes, and user interface changes. We will also update the claims data and demographic distribution being used in the AV Calculator as needed, and continue to update the AV Calculator's annual limitation on cost sharing based on a projected estimate to allow for compliance with § 156.130(a). Therefore, the major difference that we proposed under the revised § 156.135(g) was that the methodology, data sources, and trigger for making updates in the AV Calculator would be more flexible than the previous § 156.135(g). This amended provision will allow us more options in considering approaches to making changes in the AV Calculator, particularly as the health insurance market and the AV Calculator evolve, new methodological approaches are developed, and new data becomes available.

We would also not be required to make each of these changes each year, although we could include these types of material changes in our annual updating of the AV Calculator. We proposed that in developing the annual updates to the AV Calculator, we would continue to take into consideration stakeholder feedback on needed changes to the AV Calculator (through *actuarialvalue@cms.hhs.gov*) and to publicly release a draft version of the AV Calculator and the AV Calculator Methodology for comment before releasing the final AV Calculator. We are finalizing these provisions as proposed.

Comment: Commenters were concerned about the timing of the release of the AV Calculator, and wanted the AV Calculator to be available sooner. Certain commenters did not support the revised language without a timeframe. Commenters generally wanted the final AV Calculator to be available around January 1 of the preceding benefit year, in anticipation of State filing deadlines.

Response: We are finalizing the provision as proposed. One reason for changing § 156.135(g) is to provide HHS with the flexibility to update the AV Calculator sooner. We understand the importance for issuers and States to have time to use the final version of the AV Calculator to develop and adjust plan designs in advance of State filing deadlines. We believe that revised § 156.135(g) will give HHS added flexibility in changing the AV Calculator, which may result in HHS releasing the final AV Calculator earlier, such as by January 1 of the preceding benefit year. Regardless, we anticipate releasing the final AV Calculator no later than the end of the first quarter of the preceding benefit year.

Comment: Some commenters supported the flexibility for the trend factor calculation. Others expressed wanting predictable and consistent updates, wanting less frequent updates, and wanting an increase to the *de minimis* range.

Response: We recognize the importance of ensuring that the AV Calculator accurately reflects the current market and that changes to the AV Calculator minimize disruption to current plan designs through keeping AVs stable. We intend to carefully weigh these factors when making changes. We do not intend to make changes to the *de minimis* range at this time. The *de minimis* range is intended to allow plans to float within a reasonable range of +/− 2 percent.

We will also continue to work with stakeholders on the development of the AV Calculator updates. As noted above, in developing the annual updates to the AV Calculator, we will continue to take into consideration stakeholder feedback on needed changes to the AV Calculator (through *actuarialvalue@cms.hhs.gov*) and to publicly release a draft version of the AV Calculator and the AV Calculator Methodology for comment before releasing the final AV Calculator.

Additionally, we also intend to consult as needed with the American Academy of Actuaries and the NAIC on needed changes to the AV Calculator.

Comment: One commenter was concerned that the AV Calculator does not take into account the scope of networks and formularies. Other commenters asked for the Minimum Value Calculator to be updated consistently and discussed issues for large group plans that use the MV Calculator, such as accounting for the annual limitation on cost sharing.

Response: AV measures a plan's cost sharing generosity on the basis of the EHB being provided to a standard population (and without regard to the population to which that plan may actually provide benefits) to determine the level of coverage. AV is not intended to measure the scope of a network or formulary. All plans required to comply with AV must comply with EHB requirements (which establish the scope of benefits, including the formulary, being offered) and State and, in the case of QHPs, Federal laws and regulations establish a plan's network requirements.

We will work with the Department of Treasury and the Internal Revenue Service to consider whether further guidance is needed with regards to the MV Calculator. Updates to the MV Calculator are beyond the scope of this rulemaking.

f. Application to Stand-Alone Dental Plans Inside the Exchange (§ 156.150)

At § 156.150, we proposed revisions to increase the annual limitation on cost sharing for SADPs. To make adjustments to the annual limitation on cost sharing in subsequent years to keep pace with inflation, we proposed in paragraph (a)(1) that for a plan year beginning after 2016, the dollar limit applicable to a SADP for one covered child be increased by an amount equal to the product of that amount and the quotient of consumer price index for dental services for the year 2 years prior to the benefit year, divided by the consumer price index for dental services for 2016. In paragraph (a)(2), we proposed that the dollar limit for two or more covered children be twice the dollar limit for one child described in paragraph (a)(1) of this section. We sought comment on whether the premium adjustment percentage defined in § 156.130(e) should be used instead.

In paragraph (c), we proposed to define the dental CPI, which is a sub-component of the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index specific to dental services. We would use the annual dental CPI published by the Department of Labor. In paragraph (d), we proposed that increases in the annual dollar limits for one child that do not result in a multiple of $25 will be rounded down, to the next lowest multiple of $25.

We are finalizing the provision with modifications to paragraphs (a)(1) and (2) to apply the indexing formula to plan years beginning after 2017 and with a modification of the language of the formula for increasing the annual limitation on cost sharing for purposes of clarity.

Comment: Several commenters supported our proposed approach to raise the annual limitation on cost sharing over time using the CPI for dental services. Some commenters asked that the proposal be implemented sooner than for plan years beginning after 2016. Others requested using the 2014 CPI for dental services rather than the 2016 in order to have the annual limitation on cost sharing increase in the next few years. Others asked that we also consider increasing the annual limitation on cost sharing to a set level and then applying the indexing formula via the CPI for dental services in order to meet HHS's stated interest in providing preventive care without cost sharing. We also received several comments requesting clarification of the formula.

Response: When we established specific values for the annual limitation on cost sharing for SADPs in previous rules,[57] we intended to eventually index the limitation to keep pace with inflation and moderate potential increases in premiums, similar to the annual limitation on cost sharing for medical QHPs. Without such an increase, over time we could see an increase in SADP premiums and fewer affordable dental options for consumers. We believe that this formula balances the need to establish a process to increase the annual limitation on cost sharing over time against concerns with increasing the maximum financial liability to consumers.

In the regulatory impact assessment in the proposed rule, we noted our desire for consumers to have access to preventive services without cost sharing. We acknowledge that this may be difficult to achieve at the low AV level of 70 percent. However, we believe that to implement a one-time increase to the annual limitation on cost sharing by a significant amount would be overly burdensome for consumers.

Accordingly, we are finalizing the proposal as proposed, with minor modifications. We are modifying paragraphs (a)(1) and (2) to apply the indexing formula to plan years beginning after 2017 rather than 2016. We acknowledge that applying the indexing formula to plan years beginning after 2017 will ensure that the first application of the formula, for the 2018 benefit year, will result in neither an increase nor a decrease in the annual limitation on cost sharing for that benefit year. However, we are seeking to balance stability in plan designs with the desire to increase the annual limitation on cost sharing to keep pace with inflation. We will continue to monitor the increase over time to ensure we are working towards our stated goals. As noted in the proposed rule, we will propose and finalize the annual increase to the dental annual limitation on cost sharing according to the formula specified here in the annual Payment Notice.

We did not receive any comments suggesting that we use the premium adjustment percentage defined in § 156.130(e) instead. We did not receive any comments opposing our proposal to increase the annual limitation on cost sharing in $25 increments and will finalize this provision as proposed.

We also are making a modification to the wording of the formula, though not to its meaning. Under this final rule, as under the proposal, the annual limitation on cost sharing will be increased by the same percentage the CPI for dental services increased between 2016 and the year that is 2 years prior to the applicable benefit year.

Comment: A commenter asked that we clarify that the annual limitation on cost sharing would never be reduced. Another requested clarification whether the provisions would be applied to off-Exchange SADPs.

Response: We are clarifying that the proposed formula will not be used to reduce the annual limitation on cost sharing for SADPs. The updated formula language in paragraph (a)(1) specifically notes that the annual dollar limit is *increased* by the percent increase of the consumer price index for dental services. We do not include a provision that would require a reduction.

We also note that all Exchange-certified SADPs must meet the same certification standards, including the annual limitation on cost sharing, regardless of whether they are offered on or off Exchanges.

[57] Exchange Establishment Rule, 77 FR 18309 (Mar. 27, 2012); EHB Rule, 78 FR 12833 (Feb. 25, 2013).

5. Qualified Health Plan Minimum Certification Standards

a. Network Adequacy Standards (§ 156.230)

At § 156.230, we established the minimum criteria for network adequacy that health and dental plan issuers must meet to be certified as QHPs, including SADPs, in accordance with the Secretary's authority in section 1311(c)(1)(B) of the Affordable Care Act. Section 156.230(a)(2) requires all issuers to maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. Section 156.230(b) sets forth standards for access to provider directories requiring issuers to publish an up-to-date, accurate, and complete provider directory for plan years beginning on or after January 1, 2016, and § 156.230(c) requires QHPs in the FFE to make this provider directory data available on its Web site in an HHS-specified format and also submit this information to HHS in a format and manner and at times determined by HHS.

(1) State Selection of Minimum Network Adequacy Standards

The NAIC's Network Adequacy Model Review Subgroup has completed significant work in the area of network adequacy, which includes finalization of a Network Adequacy Model Act, which can be found at *http://www.naic.org/store/free/MDL-74.pdf,* that States can adopt in whole or in part. We will continue to monitor the work of the NAIC in this area and of States' implementation of these standards, and look forward to partnering with States and the NAIC in developing and promulgating network adequacy protections. In the interest of furthering this work, we proposed a number of standards related to network adequacy.

In recognition of the traditional role States have in developing and enforcing network adequacy standards, we proposed that FFEs would rely on State reviews for network adequacy in States in which an FFE is operating, provided that HHS determined that the State uses an acceptable quantifiable network adequacy metric commonly used in the health insurance industry to measure network adequacy.

We proposed that HHS would determine that a State's network adequacy assessment methodology meets the standard above if the State selects one or more standards from a list of metrics provided by HHS and applies them prospectively to the QHP issuers in the State. We anticipated including at least the following metrics in the list:

- Prospective time and distance standards at least as stringent as the FFE standard.
- Prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for its State.

We proposed that after HHS discussed with States their selection to determine whether the State's network adequacy standard would be acceptable under the standard above, we would notify issuers via regulatory guidance about whether the State standards or Federal default standard would apply.

We proposed that when HHS determined that a State's network adequacy standard is acceptable under the standard above, the State would certify to the FFE which plans meet the network adequacy standard, and the FFE in that State would rely on the State's review for purposes of determining whether a QHP meets the requirements under § 156.230(a)(2), although those issuers would still be required to submit to HHS provider data, attest to the HHS network adequacy certification requirements, and meet other applicable HHS standards, including the other standards under § 156.230.

In the proposed rule, we stated that for States that do not review for network adequacy, or do not select a standard as described above, the FFE would conduct an independent review under a Federal default standard. We proposed the Federal default standard to be a time and distance standard. For the certification cycle for plan years beginning in 2017, we stated that we anticipated evaluating the QHP issuer networks under this standard based on the numbers and types of providers, in addition to their general geographic location. The standard proposed involved using a time and distance standard at the county level. We also stated that we were considering using standards similar to those used in Medicare Advantage, utilizing the National Provider Identifier database, and focusing on the specialties that enrollees most generally use. Further, we explained that HHS was also carefully considering other network standards, including those of individual States, accrediting entities, and Federal health care programs, as it developed the time and distance standards for the FFEs.

We also stated that the proposed county-specific time and distance parameters that plans would be required to meet, including specifications for specific provider and facility types, would be detailed annually in conjunction with the Letter to Issuers.

We also proposed that issuers that did not meet the specified standards would be able to submit a justification to account for any variances, and that the FFE would review the justification to determine whether the variance is reasonable based on circumstances, such as the availability of providers and variables reflected in local patterns of care.

We explained that we did not intend in establishing these default standards to prohibit certification of plans with narrow networks or otherwise impede innovation in plan design. Instead, we stated that we intended to establish a minimum floor consistent with the levels generally maintained in the market today, so that generally a very small number of plans would be identified as having networks deemed inadequate. Our discussion of the Federal default standard was intended to provide issuers with more transparency regarding our certification processes. In that discussion, we clarified that the process would be designed and implemented to achieve results similar to those yielded by the reviews conducted by the FFEs in prior certification cycles. We explained that we believed this standard would promote predictability for issuers in the course of certification. We noted in the proposed rule that multi-State plan options will be considered to meet the network adequacy requirements under § 156.230(a)(2) if they meet network adequacy standards established by OPM.

For the reasons noted below, we are not finalizing § 156.230(d) as proposed at this time and will continue to work with States to determine how to best ensure reasonable access while preventing duplicate review.

Comment: Many commenters raised concerns about the use of a time and distance Federal default standard, and stated the new NAIC Network Adequacy Model Act does not include time and distance standards. Commenters also raised concerns that the proposed standard could increase health care costs, would not adequately address network adequacy issues in all areas, and would not fit all types of plans, and numerous commenters asked that HHS give States time to enact the new NAIC Network Adequacy Model Act rather than implementing the standard in the final rule.

Response: We appreciate the concerns raised and in response are declining to finalize § 156.230(d) as proposed for the 2017 plan year. Our intention is to give States time to adopt the NAIC Network

Adequacy Model Act provisions. We note in particular that the NAIC Network Adequacy Model Act highlights ''specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network,'' and these include provisions requiring a minimum numbers of providers, and setting limits on travel times and wait times. The Act explains how these standards can be incorporated either in statute or in regulation. Further, we note that the NAIC Network Adequacy Model Act was approved unanimously by all States and Washington, DC, and the NAIC has stated that it will be a priority of the organization to have a majority of States adopt the NAIC Network Adequacy Model Act within 3 years. We note our expectation that all States, including FFE States, will actively implement these provisions, and we look forward to monitoring States' progress this year, with a particular view to avoiding duplicative Federal and State review processes. We will revisit this proposal in future rulemaking. We will continue the process used in previous years to review network adequacy as part of the annual certification process, and will review network data for reasonable access.

For transparency, we are publishing separately details of the FFEs' internal QHP certification process for network adequacy, including the metric used for the internal review, to assess plans for network adequacy.[58] These standards are consistent with those we have used in the past to assess potential QHPs for compliance with the network adequacy requirements; we believe that providing additional transparency about these standards will help issuers with their network planning.

Comment: Many commenters expressed support for the proposed time and distance standards, and many requested specific standards for specific types of specialty care including pediatrics, cancer centers, women's health, and transplant providers. Commenters also requested that additional standards be added to the quantitative standards, including requirements regarding wait times, language services, telehealth, disability accessibility and reasonable access being provided at the lowest cost sharing tier. Some commenters also expressed concerns about the applicability of time and distance to dental issuers and urged that other standards be used. Some commenters supported the use of time and distance standards for SADPs. Some commenters requested that the time and distance standards be expanded to SBEs and multi-State plans, and that they be used as the required standards, not a default.

Response: We appreciate the comments; however, we are not finalizing the default time and distance standard at this time. As discussed above, our intention is to give States time to adopt the NAIC Network Adequacy Model Act provisions and implement associated standards.

Comment: Many commenters offered suggestions for changing and expanding the State metrics listed in the preamble, including keeping or removing the time and distance metric and provider-covered person ratios, adding the network sufficiency metrics from the recently completed NAIC Network Adequacy Model Act, adding a metric related to standards for wait times, and altering the two listed metrics to specify that they apply to specialties and subspecialties. Some commenters suggested we implement an effective network access review standard comparable to the effective rate review standard by State.

Response: We are not finalizing our proposal establishing a minimum quantitative State network adequacy measurement at this time. We wish to provide States time to adopt the NAIC Network Adequacy Model Act provisions and associated standards.

Comment: Some commenters suggested that HHS provide that only providers available through the plan's lowest tier of cost-sharing be counted for purposes of determining a network's adequacy.

Response: We intend to monitor the practice of tiering of providers and will consider implications of the practice for network adequacy review in the future. We remind all issuers, including those that use tiered networks, that they must continue to meet the current requirement in § 156.230(a)(2) to provide reasonable access to all covered services at all times throughout the plan year.

As States continue their work to implement the NAIC Network Adequacy Model Act, we will continue to use quantitative time-distance standards in our review of plans for QHP certification on the FFEs, and will be providing details of the criteria for review in the annual Letter to Issuers.

We are finalizing a number of policies relating to network adequacy. We are finalizing two provisions to address provider transitions in the FFE and a standard for all QHPs governing cost sharing that would apply in certain circumstances when an enrollee receives EHB provided by an out-of-network ancillary provider at an in-network setting. We are also finalizing our proposed policy regarding standardized categorization of network breadth for QHPs on the Federal platform.

(2) Additional Network Adequacy Standards

Under proposed § 156.230(e), which we are finalizing as paragraph (d), we proposed two new requirements to address provider transitions. First, we proposed new § 156.230(e)(1) to require QHP issuers in all FFEs to notify enrollees about a discontinuation in their network coverage of a contracted provider. We proposed that a QHP in an FFE be required to make a good faith effort to provide written notice of a discontinued provider, 30 days prior to the effective date of the change or otherwise as soon as practicable, to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

We also proposed that a discontinued provider include both a provider that is being involuntarily removed from the network, and a provider that is voluntarily leaving the network. To satisfy this requirement, we stated that we expect the issuer to try to work with the provider to obtain the list of affected patients or to use its claims data system to identify enrollees who see the affected providers. We said that we would encourage issuers, as part of the notice to consumers, to notify the enrollee of other comparable in-network providers in the enrollee's service area, provide information on how an enrollee could access the plan's continuity of care coverage, and encourage the enrollee to contact the plan with any questions.

Second, we proposed a new § 156.230(e)(2) to require that QHP issuers in all FFEs ensure continuity of care for enrollees in cases where a provider is terminated without cause. Specifically, we proposed to require the issuer, in cases where the provider is terminated without cause, to allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. We proposed the following definition of active treatment in paragraph (e)(2): (1) An ongoing course of treatment for a life-threatening condition; (2) an

[58] Final 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016).

ongoing course of treatment for a serious acute condition; (3) the second or third trimester of pregnancy; or (4) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. In relation to the proposed definition of active treatment, we stated that an ongoing course of treatment includes treatments for mental health and substance use disorders that fall within the proposed definition. For the purposes of the active treatment definition, we proposed to interpret a life-threatening condition as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; and a serious acute condition as a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy. Finally, we proposed under paragraph (e)(2)(ii) that any decisions made for a request for continuity of care be subject to the issuer's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations. We solicited comments on several issues related proposed § 156.230(e), such as the definitions of key terms and timeframes, when these provisions should apply, whether exceptions should be allowed for States that already have requirements, whether additional provisions should be allowed for continuity of care in cases of pregnancy as far as extending beyond 90 days and whether that care should limited to obstetric care and whether other provisions are needed to protect an enrollee when a provider contract is terminated.

We are finalizing these requirements as proposed, with certain modifications to better align with the NAIC Network Adequacy Model Act, including extending continuity of care coverage for the second or third trimester of pregnancy through the postpartum period and codifying the definitions of life-threatening condition and serious acute condition. Additionally, we note that these standards are not intended to, and do not, preempt State provider transition notices and continuity of care requirements, and that we intend to defer to a State's enforcement of substantially similar or more stringent standards.

Comment: Many commenters supported deferring to State provider transition policies instead of the proposals in the proposed rule, with some commenters only supporting deference when the State has stronger consumer protections. Justifications for deferring to State provider transition policies included problems with conflicting State law and the associated burden with conflicting requirements. In the absence of applicable State laws, some commenters recommended aligning standards to those in the NAIC Network Adequacy Model Act that are administratively feasible or allow issuers to maintain their current practices.

Response: We are finalizing these proposed provider transition policies in § 156.230(d), but note that these standards are not intended to, and do not, preempt State provider transition notices and continuity of care rules, and that we would defer to a State's enforcement of substantially similar or more stringent requirements. This flexibility would apply to any State that chooses to enact these parts of the NAIC Network Adequacy Model Act under section 6(L).[59] We recognize that the NAIC Network Adequacy Model Act differs in certain respects from our requirements under § 156.230(d)(1) and (2); we intend to monitor States' implementation of the NAIC Network Adequacy Model Act and may consider revisions to this policy in the future if needed.

Comment: Some commenters wanted more than 30 days' notice, or asked that the timeframes align with the NAIC Network Adequacy Model Act. Some commenters supported requiring all enrollees of a primary care provider to be required to be notified. Other commenters stated that the notices should not be required if providers are leaving a practice with other in-network providers from that practice available. Some commenters advocated for the development of enrollee registries through which enrollees can be informed of changes or receive a list of providers being discontinued. Some commenters expressed concern about the value of notifications, and others expressed concern about the confidentiality of provider notices.

Response: We are finalizing the notice requirements at § 156.230(d)(1) as proposed. While our notice requirements are not the same as those in the NAIC Network Adequacy Model Act, we did consider these notice requirements and requirements from other programs in proposing § 156.230(d)(1). We understand that issuers need timely notification from the provider leaving the network in order to meet the 30-day timeframe, but as the issuer has the contracting relationship with the provider, the issuer is in the best position to require providers to provide a termination notice to the issuer.

We note that paragraph (d)(1) requires that the issuer make a good faith effort to provide the required notification. We understand that there are certain situations that cannot be anticipated, and in those cases, we would expect the issuer to send the notice to the enrollee as soon as practically possible. Issuers can send the notification to the enrollee electronically or by mail. In response to comments, we clarify that when the provider is leaving a practice, and as a result will no longer belong to the issuer's network, but other providers from the practice remain in-network, paragraph (d)(1) would not require the issuer to provide notice to the enrollees. We believe in those cases the provider's practice is better positioned to provide notification to the enrollee.

Comment: Comments on the appropriate definition of ''regular basis'' generally either preferred to leave the definition to the discretion of the issuer or suggested that we define it to include an enrollee that has received services from the provider within one year. Some commenters specifically wanted the definitions related to primary care from the NAIC Network Adequacy Model Act to be incorporated in the rule to clarify how the provisions under paragraph (d)(1) should apply. Some commenters wanted additional protections in cases of provider transitions, such as special enrollment periods for provider terminations, or limits on the ability of issuers to terminate providers mid-year (or recourse for the providers in the event of such a termination), while other comments expressed concern about the difficulty in coordinating with providers to identify affected enrollees. Other commenters wanted issuers to be required to include information in the notice about other comparable in-network providers and to inform the enrollee of rights to receive continuity of coverage.

Response: The purpose of § 156.230(d)(1) is to ensure that enrollees are notified of changes to their provider network on a timely basis. At this time, we are not extending this provision to include additional requirements. However, notwithstanding a provider termination, all QHP issuers are required under § 156.230(b) to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that

[59] See *http://www.naic.org/store/free/MDL-74.pdf.*

all services will be accessible without unreasonable delay. For purposes of paragraph (d)(1), we will not finalize a uniform definition of regular basis at this time, and will permit issuers to implement a reasonable definition of that term. The NAIC Network Adequacy Model Act similarly did not include a definition of regular basis. For purposes of paragraph (d)(1), we note that, in alignment with the NAIC Network Adequacy Model Act, we generally understand primary care to mean health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider, and a provider of primary care to mean a participating health care professional designated by the issuer to supervise, coordinate, or provide initial care or continuing care to an enrollee, and who may be required by the issuer to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person, but that an issuer may implement reasonable definitions of these terms. To identify enrollees who see a provider who is terminating, we expect the issuer to work with the provider to obtain the list of affected patients, use its claims data system to identify enrollees who see the affected providers, or use another reasonable method. The issuer does not need to use more than one method. For the written notice required under paragraph (d)(1), we encourage issuers to notify the enrollee of other comparable in-network providers in the enrollee's service area, provide information on how an enrollee may access the plan's continuity of care coverage, and encourage the enrollee to contact the plan with any questions.

Comment: Some commenters stated that continuity of care should cover non-renewals and terminations without cause; other commenters disagreed. Commenters sought clarifications regarding the cost sharing during the continuity of care period, and some commenters asked us to adopt provisions from the NAIC Network Adequacy Model Act, including providing that the issuer is only required to provide the continuity of care if the provider agrees to accept the previously contracted in-network rate and to ensure protections against balance billing. Some stated that failure to include such a request could increase premiums.

Response: While we expect issuers to negotiate with a provider for payment for services under § 156.230(d)(2), issuers would only be responsible for paying to a provider what was previously being paid under the same terms and conditions of the provider contract, including any protections against balance billing, if the provider agrees to provide care under § 156.230(d)(2). We cannot require non-contracted providers to accept a particular payment rate under § 156.230(d)(2). Therefore, nothing under § 156.230(d)(2) would prohibit balance billing for non-contracted providers in accordance with section 1302(c)(3)(B) of the Affordable Care Act and § 155.20. This means that an enrollee could be balance billed for the services under § 156.230(d)(2), absent another prohibition on balance billing in this situation, and those balance billing amounts would not be required to count toward the plan's annual limitation on cost sharing established at § 156.130.

In response to comments, we are limiting paragraph (d)(2) to cases where the provider is terminated without cause, including non-renewals without cause, and clarify that § 156.230(d)(2) does not apply in cases where the contract is terminated or not renewed with cause. A termination or non-renewal without cause could be initiated by either the issuer or the provider or could be mutual. In any of these cases, enrollee continuity of care should be ensured. Furthermore, we clarify that if the enrollee remains in the same plan across plan years, § 156.230(d)(2) will apply across plan years. However, if an enrollee switches plans, § 156.230(d)(2) would not apply, since there would not necessarily be an expectation that the same provider would be available under the new plan.

Comment: Some commenters sought clarifications or expansions of the proposed definition of the course of active treatment, such as changes that would require inclusion of certain conditions or transitional coverage of drugs. While some commenters sought clarifications on the definition of active treatment or wanted the issuer's medical director to make the determination of whether an enrollee was in the course of active treatment, commenters generally supported the proposed definition of ''active treatment'' and our proposal that would make the continuity of coverage rule subject to internal and external appeal processes. Commenters supported requiring continuity of coverage for pregnancy through the post-partum period. Some commenters also sought 90 days as the minimum transitional period, not the maximum period for continuity of care coverage, or urged us to adopt a longer or shorter period.

Response: We are not making changes to the definition of ''active treatment'', except to amend the definition to ''active course of treatment'' to align with the language in the NAIC Network Adequacy Model Act. This change is not intended to alter the meaning of the proposed rule. We are also finalizing, to align with the NAIC Network Adequacy Model Act, the definitions of a life-threatening condition as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; and a serious acute condition as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits. For the purposes of the active course of treatment definition, an ongoing course of treatment includes treatments for mental health and substance use disorders that fall within the definition of active course of treatment. Additionally, if the enrollee has successfully transitioned to a participating provider, if the benefit limitations of the plan are met or exceeded, or if care is not medically necessary, § 156.230(d)(2) would no longer apply to the enrollee.

In response to comments supporting the extension of this policy to cases of pregnancy, we are revising the definition of active course of treatment to include the second or third trimester of pregnancy through the postpartum period. We are leaving the definition of what constitutes ''postpartum period'' and the scope of related services to the reasonable interpretation of the issuer.

At § 156.230(f), which we are now finalizing as paragraph (e), we proposed to require, notwithstanding § 156.130(c) of the subpart, that for a network to be deemed adequate, each QHP that uses a provider network must count cost sharing paid by an enrollee for an EHB provided by an out-of-network provider in an in-network setting under certain circumstances towards the enrollee's annual limitation on cost sharing. Alternatively, we proposed that the plan could provide a written notice to the enrollee at least 10 business days before the provision of the benefit that additional costs may be incurred for EHB provided by an out-of-network provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

We solicited comments on whether 10 business days' advance notice is the appropriate timeframe. We also sought comment on whether issuers should be

required to provide customized information to the consumer (including information on potential in-network providers) or if a form notification would be sufficient. We proposed that this policy would apply to all QHP issuers, in all Exchanges.

We are finalizing our proposed policy, with four modifications. First, we provide that this policy would only apply to cost sharing paid by an enrollee for an EHB provided by an out-of-network *ancillary* provider in an in-network setting. Second, we are shortening the timeframe from 10 business days to the longer of the issuer's prior authorization timeline (that is, when the issuer would typically respond to a prior authorization request submitted timely) or 48 hours prior to the scheduled service. Third, we are finalizing this proposal so that it will take effect beginning for the 2018 benefit year. Fourth, we are making a minor edit for clarity.

Comment: Many commenters supported HHS's efforts to address surprise out-of-pocket costs for consumers. Other commenters supported the proposal, but felt that it did not go far enough to protect consumers, and stated that HHS should consider including a prohibition on balance billing or otherwise restricting consumer financial responsibility in these scenarios. Other commenters thought that it may be difficult for consumers to locate an in-network provider within this timeframe. Commenters also suggested expanding the proposal to include situations in which an in-network provider is not available, when the provider directory is not up to date, and emergency care.

Several commenters did not support our proposal, and asked that States be given the time and discretion to implement network adequacy standards. Others requested that HHS adopt NAIC Network Adequacy Model Act provisions instead. Other commenters were concerned that the proposal may have unintended consequences, such as disincentivizing providers from contracting with issuers in order to be able to balance bill consumers, or incentivizing consumers and out-of-network providers to elect to perform procedures at an in-network facility.

Response: We are finalizing, for the 2018 and later benefit years, a modified § 156.230(e) to count services provided by an out-of-network ancillary provider in an in-network facility towards the in-network annual limitation on cost sharing if the issuer does not provide timely notice, with the modifications described above. We did not propose to prohibit balance billing by out-of-network providers or limit the financial liability associated with out-of-network services to consumers. Our intent in establishing this policy beginning for the 2018 benefit year is to permit us to monitor ongoing efforts by issuers and providers to address the complex issue of surprise out-of-network cost sharing at in-network facilities across all CMS programs in a holistic manner, and amend our policy in the future to accommodate progress on this issue, if warranted.

While not a solution to all adverse financial consequences of receiving treatment from an out-of-network provider in this situation, we believe the policy we are finalizing will help provide transparency and ensure that consumers receive notice of the possible consequences where an out-of-network ancillary provider may be seen and are provided some mitigation of these consequences where proper, timely notice is not provided by the issuer. We believe that this policy provides a measure of financial protection for consumers against surprise out-of-network cost sharing, while maintaining the larger part of the QHP's cost-sharing structure and avoids significant impacts on premiums.

We are making a modification to this policy to limit its application to ancillary providers (that is, the provider of a service ancillary to what is being provided by the primary provider, such as anesthesiology or radiology) rather than the services supplied by the primary provider. In response to comments, we were concerned that the proposed policy could have had the unintended consequence of providing for reduced cost sharing for a primary provider, such as a surgeon *known* to be out-of-network. We acknowledge commenters' concerns that as previously written, the policy could allow for a consumer who has selected an out-of-network provider to deliberately seek to have the services rendered in an in-network facility in order to reduce cost sharing. We believe that this modification will address this concern.

We intend to continue to monitor these situations, including issuers' timely compliance with this provision to consider whether further rulemaking is needed. Lastly, as we stated in the proposed rule, this proposal is not intended to, and does not, preempt any State laws on this topic.

Comment: Some commenters supported the requirement that issuers notify consumers of the potential for additional cost-sharing from out-of-network providers, but did not support the exception for issuers to not count the cost sharing towards the annual limitation on cost sharing. Others thought that the notification timeframe of 10 days was arbitrary, not long enough for consumers to arrange in-network care, or too long because prior authorization frequently happens closer to service delivery. Some commenters requested that facilities be required to notify consumers about whether or not providers were in-network for a consumer. Others noted that the 10 days' notice timeframe prior to the service may incentivize issuers to delay approval to utilize the notification exception.

Commenters also provided feedback on the type of information that should be included in a notice—many suggested that issuers be required to include information on available network providers, information on costs, and how a consumer could appeal a determination. Other commenters thought the notification process was overly burdensome for issuers, especially if customized information was required.

Response: In response to comments, we are modifying the 10-day timeline to account for issuers' prior authorization timelines. We are requiring notice from issuers by the longer of the issuer's prior authorization timeline (that is, when the issuer would typically provide the prior authorization) or 48 hours. This new timeline is more in line with existing issuer prior authorization timelines and will be less administratively burdensome for QHP issuers to implement, while providing consumers with the same time period to adjust their plans that they would have with respect to notification of prior authorization.

We are also finalizing our proposal that a form notice be provided to the enrollee in these circumstances indicating that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing. While customized information for each consumer is preferable, we understand that creating such a notice may be burdensome to QHP issuers and may delay the notification process. Additionally, the provider directories that QHP issuers must provide may ease the burden on the enrollee to find an appropriate in-network provider. Therefore, while we are not requiring that customized information be provided to the enrollee in these circumstances, including

information on available network providers, costs, and how a consumer could appeal a determination, we strongly encourage QHP issuers to provide that information.

Comment: Commenters asked if § 156.230(e), which was proposed § 156.230(f), would apply to QHPs with tiered networks or QHPs that do not provide out-of-network services. Another commenter asked for clarification on whether this provision would apply to QHPs on and off Exchanges. Other commenters asked HHS to clarify that this does not apply to emergency services which are already covered by § 147.138(b).

Response: We clarify that § 156.230(e) applies to QHPs, both on and off Exchanges, and to QHPs with tiered networks, but it does not apply to QHPs that do not cover out-of-network services. It also does not apply to emergency services, which are governed by other Federal regulations.

Comment: Several commenters requested that § 156.230(d) and (e) not apply to SADPs as the NAIC determined that these types of standards were not necessary for dental plans. The commenters stated that the structure of SADPs and the services covered by SADPs are different from medical plans as dental services are scheduled well ahead of time, the course of treatment does not include more serious conditions, and services are almost uniformly provided in the dentist's office.

Response: While we agree that these provisions are more suitable to medical services, § 155.1065 provides that SADPs must meet QHP certification standards, except for any certification requirement that cannot be met because the SADP is an excepted benefit that provides only a limited scope of coverage. However, we also believe due to the nature of these policies and the services provided by SADPs that any instances in which a SADP would need to apply these provisions would be rare.

(3) Other Comments on the Preamble to § 156.230

In the proposed rule, we solicited comments on a number of other network adequacy standards, including standards included in the work being done by the NAIC's Network Adequacy Model Review Subgroup. Our solicitation of comment included:

- Whether a QHP in an FFE should have a network resilience policy for disaster preparedness. Network resilience refers to the provider network's capacity to withstand and recover from natural or man-made disasters that may threaten enrollees' continuous access to quality care.
- Whether measuring network adequacy based on enrollee wait times for scheduled appointments, including the variation in wait times depending on the type of provider, such as for primary care or non-primary care services, and whether we should add a wait time standard as an option under the proposed permissible State standards mentioned in the proposed rule, or if we should apply a broad wait time standard across QHPs in the FFEs.
- Whether an issuer should be required to survey all of its contracted providers on a regular basis to determine if a sufficient number of network providers are accepting new patients.
- Whether issuers should be required to make available their selection and tiering criteria for review and approval by HHS and the State upon request.

We also stated that we were considering providing on HealthCare.gov a rating of each QHP's relative network coverage. This rating or classification would be made available to a consumer when making a plan selection. We explained that such a rating would help an enrollee select the plan that best meets his or her needs, and that we anticipated that this analysis would compare the breadth of the QHP network at the plan level as compared to the breadth of the other plan networks for plans available in the same geographic area.

We stated that we anticipated analyzing the QHP network by calculating the number of specific providers that are accessible within specified time and distance standards. We explained that we would then classify the QHP networks into three categories. We stated that we were considering performing the calculation based on the provider information submitted by all QHP issuers in the existing network adequacy FFE QHP certification template.

In the proposed rule, we explained that this network breadth rating would allow an enrollee to better understand plans' designs, and, like other consumer tools, could help improve plan satisfaction. We stated that we anticipated providing additional details about how we would classify networks in the Letter to Issuers and in the QHP certification instructions, and we solicited comments on what types of methods should be used to identify each network's breadth, what specific specialties should be included in the analysis, what sorts of adjustments should be made to address provider shortages, and other possible data sources to obtain information about available providers in the area. We also welcomed comments on the best way to make this information available to consumers. We intend to implement this proposal for open enrollment for the 2017 benefit year, if following consumer testing we determine that we can display this information in a manner useful to consumers. At this time, we plan to provide the classifications of network breadth for each plan at the county level. These classifications will be determined by calculating the percentage of providers in a plan's network, compared to the total number of providers in QHP networks available in a county. We plan to provide additional details on this methodology in the Letter to Issuers.

Comment: Commenters had concerns about Federal requirements on network resilience, such as geographic variation issues. Others generally support network resilience policies offering recommendations, such as broad standards, deferring to States if they have strong standards, or Medicare standards.

Response: We intend to work with stakeholders to consider best practices for network resilience policies. We want to ensure that any standards that we consider in this area are reasonable and operationally feasible, and take into account geographical variation.

Comment: Some commenters had concerns about requiring providers to be surveyed on whether they are accepting new patients because of concerns about accuracy of this reporting, the associated difficulty and burden on issuers and providers, the risk of undermining current efforts by stakeholders to improve data quality, and concerns about ''accepting new patients'' being a poor standard for determining network sufficiency. Other commenters generally supported requiring issuers to survey providers on whether they are accepting new patients, as the information could be used to update the provider directory.

Response: In the 2016 Payment Notice, we finalized requirements under § 156.230(b) that a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. We also stated that all the required data, including information on whether a provider is accepting new patients, are critical for consumers to

make educated decisions about their health coverage. While we believe that it is important that enrollees have access to providers who are willing to accept new patients and issuers should ensure providers are available within the network, we intend to continue to monitor this issue, including industry's efforts in this area, to consider whether further requirements are needed.

Comment: Some commenters had concerns about issuers being required to provide selection and tiering criteria, noting the information is proprietary and that greater regulatory authority over network adequacy could have a chilling effect on network and product design. Other commenters supported such a provision. Many noted concerns that issuers are currently only making selection and tiering determinations on costs and not quality, and oversight of this criteria could prevent discrimination.

Response: We encourage issuers to be more transparent about selecting and tiering criteria. We believe that transparency of selecting and tiering criteria would help enrollees and providers better understand how the issuer designed its network, which could help enrollees use the network more effectively and efficiently.

Comment: Some commenters opposed a wait time standard, stating it is difficult to measure and assess consistently across providers, operationally and technically challenging for issuers, does not take into account quality, and would be problematic to apply across all FFEs given State variation. Other commenters supported requiring issuers to comply with wait time standards. Many supported applying such a requirement to all QHPs or all QHPs in FFEs.

Response: We understand that a Federal wait time standard would need to take into consideration market and geographical variation of States. We intend to continue to monitor the use of and development of wait time standards.

Comment: Some commenters supported providing network breadth information to consumers at the time of plan selection, and supported the implementation we described. Other commenters raised concerns about a rating system, believing it might be problematic because it does not factor in quality and could be confusing. Some commenters requested comprehensive consumer testing. Some commenters also requested that the rating information should include both physicians and hospitals.

Response: We plan to proceed with providing information about each QHP's relative network breadth on HealthCare.gov. We will base the rating information of the network data for each QHP that is submitted as part of the certification process. This rating will be made available to a consumer when making a plan selection. We are conducting consumer testing to help inform how to display the rating in a way that will assist the consumer in selecting the plan that best meets his or her needs. We anticipate providing details about what specialties the ratings will include in the 2017 Final Letter to Issuers and in the QHP certification instructions.

Comment: Commenters provided comments on other network adequacy issues, such as wanting additional requirements on provider directories, provider non-discrimination, access to specialized care, strong oversight and enforcement of network adequacy standards, and standards for material network changes. Other commenters wanted the proposed provisions to apply to all QHPs instead of QHPs in FFEs only.

Response: We are not implementing additional network adequacy related provisions at this time. Our intention is to give States time to adopt the NAIC Network Adequacy Model Act provisions and potentially reconsider this area in the future. Therefore, we are finalizing new § 156.230(d) to apply to all QHPs in an FFE only, and new § 156.230(e) to apply to all QHPs.

b. Essential Community Providers (§ 156.235)

On June 5, 2015, we proposed through a Paperwork Reduction Act (PRA) notice a provider petition process to update the ECP list against which issuer compliance with the ECP standard is measured. We completed this data collection for the 2017 benefit year and will provide additional opportunities for ECPs to submit provider data to HHS for benefit years beyond 2017. The degree of provider participation in this data collection effort has allowed HHS to assemble a more complete listing of ECPs.

In the proposed rule, we proposed that, for the 2017 QHP certification cycle, HHS would continue to credit a health plan seeking certification to be offered through an FFE with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. For QHP certification cycles beginning with the 2018 benefit year, we sought comment on whether we should revise § 156.235(a)(2)(i) and (b)(2)(i) to credit issuers for multiple contracted full-time equivalent (FTE) practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the ECP facility through the ECP petition process. We proposed to apply this FTE count to the numerator of an issuer's percentage satisfaction of the general ECP standard described in paragraphs (a)(1) and (2) of § 156.235 and the alternate ECP standard described in paragraphs (b)(1) and (2) of that section. We proposed that the denominator of an issuer's percentage satisfaction of the ECP standard would reflect the number of available FTE practitioners reported to HHS by each ECP facility located in the issuer's plan service area.

In the proposed rule, we stated that our analysis of the available ECPs in each of the additional ECP subcategories previously considered for disaggregation (that is, children's hospitals, rural health clinics, freestanding cancer centers, community mental health centers, and hemophilia treatment centers) does not support further disaggregation of these categories at this time. We explained that there are too few ECPs within each of these additional ECP categories appearing on our ECP list to afford issuers sufficient flexibility in their contracting. We stated that we may revisit this consideration in the future, and encouraged QHP issuers to include in their networks these additional providers to best meet the needs of the populations they serve.

We are finalizing the provisions under § 156.235 as proposed.

Comment: We received numerous comments in support of our proposal for benefit year 2017 to continue crediting a health plan seeking certification to be offered through an FFE with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. Other commenters urged that HHS credit issuers for multiple contracted FTE practitioners at a single location.

We received many comments in support of our proposal for QHP certification cycles beginning with the 2018 benefit year to credit issuers that qualify for the general and alternate ECP standard for *multiple* contracted FTE practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the ECP facility. These commenters stated that the wide variability in the number of available practitioners at each ECP facility and broad range of health care services that ECPs provide favor this position, and urged that ECP facilities

should not all be credited equally toward an issuer's satisfaction of the 30 percent ECP standard. In addition, they stated that many issuers contract with multiple unaffiliated providers that rent space in the same building and should be credited for more than one ECP at that location. Some of these commenters stated that while they support crediting issuers for multiple ECPs at a given site, they urged us to not rely solely on issuer satisfaction of the 30 percent ECP threshold to ensure adequate access to care for low-income medically underserved individuals.

We also received comments in opposition to this proposal for benefit year 2018. Many of the commenters stated that issuers do not always know how many FTE practitioners are available at a specific provider facility, and it would be burdensome for issuers to be required to collect such provider data. Many commenters opposed the proposal due to concerns that the policy might not ensure geographic distribution of ECPs and an adequate range of health care services provided by ECPs.

A few commenters stated that FTE practitioners at a facility often fluctuate, or they divide their time among several facilities, and so FTEs might be an unpredictable measure of an issuer's satisfaction of the ECP standard.

Response: On December 9, 2015, HHS launched its ECP petition initiative to give providers an opportunity to request to be added to our ECP list, update their provider data on our ECP list, and provide missing provider data, including FTE practitioner data that issuers rely upon to identify qualified ECPs for inclusion in their provider networks. The web-based ECP petition link is available at *https://data.healthcare.gov/cciio/ecp_petition.* HHS anticipates that this provider data collection initiative will require several months of provider outreach in order to collect the requisite FTE practitioner data. For benefit year 2017, we are finalizing our proposal at § 156.235(a)(2)(i) to count multiple providers at a single location as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard.

For QHP certification cycles beginning with the 2018 benefit year, we are finalizing our proposal at § 156.235(a)(2)(i) to credit issuers for multiple contracted FTE practitioners at a single location, up to the number of available FTE practitioners reported to HHS by the ECP facility through the ECP petition process. As HHS collects the number of FTE practitioners from providers via the ECP petition for purposes of the benefit year 2018 certification cycle, HHS intends to clarify to issuers through guidance that issuers must report on their ECP template only the number of FTE practitioners at each ECP facility that the issuer has included in its provider networks for its member enrollees. That number must not exceed the number of available FTE practitioners reported to HHS by the ECP facility through the ECP petition process. Due to the wide variability in the number of available practitioners at each ECP facility and broad range of health care services that ECPs provide, HHS believes that this methodology for calculating an issuer's satisfaction of the ECP standard will provide a more accurate representation of the issuer's ECP participation in its provider networks.

For benefit years 2017 and beyond, HHS will continue to require issuers to satisfy the separate ECP requirement to offer a contract in good faith to at least one ECP per ECP category, where an ECP in that category is available, within each county in the plan's service area. In addition, issuers must continue to offer a contract to all available Indian health care providers in the plan's service area. In previous years, HHS relied in part on crediting a health plan with multiple providers at a single location as a single ECP toward the issuer's satisfaction of the ECP participation standard to better ensure geographic distribution of ECPs. For benefit year 2018, HHS expects to have collected the necessary ECP category-specific data directly from all qualified providers on our ECP list via the ECP petition initiative, so that reliance on counting multiple providers at a single location as a single ECP will no longer be necessary for purposes of ensuring geographic distribution of ECPs. We expect that the ECP category per county contract offering requirement will serve to better ensure geographic distribution of ECPs and an adequate range of health care services.

In order to address fluctuations in FTE practitioners at a facility, HHS intends to keep the ECP petition submission window open throughout the year, permitting providers to report the fluctuations and for issuers to view these updates in preparation for the following benefit year contract negotiations. For provider facilities that employ or contract with practitioners who divide their time among several facilities, the ECP should divide their FTE counts among the facilities when completing the ECP petition. For instance, an ECP should report a practitioner who practices half time at two separate facilities as 0.5 FTE at each facility to ensure a more accurate count of FTEs at each facility. Lastly, HHS has instructed providers to submit only one ECP petition for each facility location using the facility-level National Provider Identifier (NPI), rather than each individual practitioner at the facility submitting a separate ECP petition. Therefore, HHS intends to continue reflecting only facility-level ECPs on its ECP list, although some facilities may be composed of a solo practitioner beginning with the 2017 benefit year ECP list.

For the reasons stated above, we are finalizing our proposal to revise § 156.235(a)(2)(i) and § 156.235(b)(2)(i) to credit issuers that qualify for the general or alternate ECP standard described in § 156.235 that seek certification to be offered through an FFE (or SBE–FP) for multiple contracted FTE practitioners at a single location toward the issuer's satisfaction of the ECP standard, beginning with the 2018 benefit year. In addition, we are finalizing our proposal that for the 2017 benefit year, HHS will continue to credit an issuer that qualifies for the general or alternate ECP standard and is seeking certification to be offered through an FFE with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard.

Comment: Several commenters urged that HHS disaggregate the providers listed in the ''Hospitals'' ECP category and the ''Other ECP Providers'' category. These commenters stated that by grouping together providers such as hemophilia treatment centers, community mental health centers, and rural health clinics into one ECP category, HHS runs the risk that low-income, underserved enrollees will have inadequate access to key providers that are uniquely suited to meet their specialized health needs. These commenters urged that HHS modify the ECP categories to separate the distinct entities and require contracting with each of them. Several commenters expressed concern that children's hospitals are grouped with hospitals that do not specialize in children's health care services. These commenters emphasized that children's hospitals are uniquely suited to meet the needs of children with complex medical conditions, and they urged HHS to establish a separate ECP category for children's hospitals. Some commenters expressed concern that HHS might be underestimating the number of providers in each of these ECP

subcategories, because the ECP categories reflected on the benefit year 2016 ECP list combine these providers with other provider types, rather than classifying them separately. One commenter recommended that HHS require that health plans offer contracts to all ECPs from each of the categories in each county that is in a health professional shortage area (HPSA), with the Health Resources and Services Administration serving as a resource for identifying those areas. In contrast, several health plans supported not disaggregating the ECP categories, expressing concern that issuers would not have sufficient flexibility in contracting.

Response: Based on our analysis of the available ECPs in each of the additional ECP subcategories previously considered for disaggregation (that is, children's hospitals, rural health clinics, freestanding cancer centers, community mental health centers, and hemophilia treatment centers), we believe that too few ECPs appear on the ECP list to afford issuers sufficient flexibility in their contracting. In order to address this concern, HHS launched its ECP Petition initiative on December 9, 2015, to give providers an opportunity to request to be added to the ECP list, update their provider data on the ECP list, and provide missing provider data. Provider participation in this ECP petition initiative is critical to ensure that issuers are aware of a provider's ECP status and that accurate provider data are reflected on the ECP list, including ECP category classifications. We believe that HHS's network adequacy standards, coupled with the ECP standards, including the 30 percent inclusion standard and the requirement that issuers offer a contract to at least one ECP in each ECP category in each county in the plan's service area, afford both providers and issuers sufficient contracting flexibility as HHS continues to update the ECP list. In addition, we continue to partner with HRSA to identify HPSAs for determining provider qualification for inclusion on the ECP list.

Comment: Several commenters urged that HHS require QHP issuers to contract with any willing provider, rather than only 30 percent of the available ECPs in a plan's service area. Some of these commenters suggested that HHS require that QHP issuers offer good faith contracts to all willing providers in specific ECP categories (that is, FQHCs, Ryan White providers, hemophilia treatment centers) in the plan's service area.

Response: While we appreciate the commenters' suggestions, we did not propose changes to the 30 percent ECP standard and consider these comments to be outside the scope of the proposed rule.

c. Enrollment Process for Qualified Individuals (§ 156.265)

Under § 156.265(b)(2), if an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange (direct enrollment through an issuer), the QHP issuer must redirect an applicant directly to the Exchange Web site to complete the application and receive an eligibility determination. HHS requested comment on an option to enhance the direct enrollment process, like that described in this final rule in the preamble to § 155.220, such that an applicant could remain on the QHP issuer's Web site to complete the application and enroll in coverage, and the QHP issuer's Web site could obtain eligibility information from the Exchange in order to support the consumer in selecting and enrolling in a QHP. Our intent is to have this information exchange occur through an Exchange-approved Web service to provide Exchanges offering direct enrollment and QHP issuers more operational flexibility to expand front-end, consumer-facing channels for enrollment through a more seamless consumer experience. Accordingly, as in § 155.220, we proposed to revise § 156.265(b)(2)(ii) to ensure that an applicant who initiates enrollment directly with the QHP issuer for enrollment through the Exchange receives an eligibility determination for coverage through the Exchange Web site or through an Exchange-approved web service via the FFE single streamlined application. Comments regarding the enhanced direct enrollment proposal by web-brokers are discussed in this final rule in the preamble to § 155.220. We sought comment on the same direct enrollment options for issuers, including whether to expand oversight, auditing and monitoring activities, and how to best maintain privacy and security standards. We also solicited comments on whether standards should differ for a web-broker compared to a QHP issuer. We did not receive comments indicating standards should differ for a web-broker compared to a QHP issuer in regards to direct enrollment; thus, we are finalizing the proposal to require effectively the same set of standards regarding direct enrollment.

Comments on the general enhanced direct enrollment proposal, use of the FFE single streamlined application, HHS approval of alternative enrollment pathway processes, and the timing of direct enrollment are discussed in this final rule at the preamble to § 155.220(c)(3).

Comment: Commenters aligned their comments for web-brokers with comments for issuers, and a few commenters generally noted that a level playing field is essential to Exchange stability.

Response: Based on the comments received, as summarized above, we are finalizing the proposal to enhance the direct enrollment process with some modifications, as noted below.

We appreciate the many comments and recommendations on the direct enrollment proposal we received. While we believe that an enhanced direct enrollment process will provide a more seamless consumer experience, we agree with commenters that implementing the proposal will be a significant undertaking for HHS, web-brokers, and issuers, and that such an effort will require sufficient time for operational planning and preparations, such as identifying and testing the Exchange-approved web services under § 156.265(b) that can be used to support the enhanced direct enrollment process, and ensuring privacy and security risks are addressed and mitigated. HHS will not provide such an option during the individual market open enrollment period for 2017 coverage, but intends to provide the option by the open enrollment period for 2018 coverage. We intend to supplement the framework we are finalizing in this rule with more specific guidance and requirements in future rulemaking, such as specific guidelines for a pre-approval process under § 156.265(b)(3), and requirements for privacy and security. Until then, issuers must continue to comply with the current direct enrollment process, through which a consumer is directed to HealthCare.gov to complete the eligibility application, and all associated guidance. This means direct enrollment entities are not permitted at this time to use non-Exchange Web sites to complete the Exchange eligibility application or automatically populate data collected from consumers into HealthCare.gov through any non-Exchange Web site. Completion of the Exchange eligibility application on a non-Exchange Web site, or collection of data through a non-Exchange Web site that is then used to complete the eligibility application will be considered a violation of the direct enrollment entity's agreement with the FFEs.

See preamble to § 155.220(c)(3), above, for a discussion of the existing direct enrollment requirements.

While enhanced direct enrollment will not be available in the individual

market open enrollment period for 2017 coverage, we are finalizing our proposal to revise § 156.265(b)(2)(ii) to enable issuers who use HHS-approved direct enrollment processes to facilitate enrollment through the FFEs to either ensure the applicant's completion of an eligibility verification and enrollment through the Exchange internet Web site as required by § 155.405, or ensure that the eligibility application information is submitted for an eligibility determination through an Exchange-approved web service. This will allow applicants to complete the entire Exchange application and enrollment process on the web-broker's non-Exchange Web site. We believe this process will grant direct enrollment entities the operational flexibility to expand front-end, consumer-facing channels for enrollment.

However, we also share commenters' concerns that allowing this flexibility without additional protections in place may increase the risk of imprecise, inaccurate, or misleading eligibility results. In light of those considerations and the accompanying comments received, we are adding new paragraphs (b)(3)(i) through (iii) to clearly articulate the requirements associated with completing an Exchange eligibility application on a direct enrollment entity's non-Exchange Web site. These requirements may be amended over time as implementation activities begin and once experience is gained under the new process (once implemented).

Consistent with the proposal in the proposed rule, § 156.265(b)(3)(i) requires all language related to application questions, and the sequence in which the questions are presented on the direct enrollment entity's non-Exchange Web site to be identical to that of the FFE Single Streamlined Application. We acknowledge the comments requesting deviations from the FFE single streamlined application to enhance the consumer experience, and, as we are for web-brokers, we are finalizing language permitting such deviations with HHS approval. We will only approve minor modifications that do not change the intent or meaning of the questions, decrease the probability of accurate answers and eligibility determinations, or affect the dependencies and structure of the dynamic application.

We are also adding new § 156.265(b)(3)(ii), which sets out a more general requirement that any non-Exchange Web site facilitating the completion of an Exchange eligibility application ensure that all information necessary for the completion of the application related to the consumer's applicable eligibility circumstance are submitted through the Exchange-approved web service. New § 156.265(b)(3)(iii) requires that the process used for consumers to complete the eligibility application on the non-Exchange Web site comply with all applicable Exchange standards, including Exchange notice requirements under § 155.230 and Exchange privacy and security standards related to handling PII under § 155.260(b).

We also agree with commenters that urged HHS to adopt an approval process to ensure that the non-Exchange Web site seeking to offer stand-alone direct enrollment eligibility services meets all applicable requirements in order to protect consumers. Accordingly, we have added § 156.265(b)(4) to outline a process for HHS to verify entities meet all requirements of this section prior to using a non-Exchange Web site to complete the Exchange eligibility application.

See preamble under § 155.220 for a discussion on the primary objective of these changes.

We clarify that the requirements related to the direct enrollment process rules are applicable to FFEs (including FFEs where States perform plan management functions) and SBE–FPs only, and would not apply to SBEs that do not use the Federal platform, nor alter any State-specific rules related to Medicaid eligibility.

Comment: Commenters generally supported HHS conducting regular audits on issuers and requiring issuers to adhere regulatory standards for direct enrollment activities.

Response: We agree with commenters that supported HHS conducting regular audits of issuers under this section to ensure ongoing compliance with applicable standards and are adding § 156.265(b)(5), which enables HHS to periodically monitor and audit entities to assess compliance with standards in this section.

Comment: One commenter stated HHS should work with issuers as it develops new direct enrollment functionality, leverage existing security standards as much as possible, and leave sufficient time for testing and implementation of any requirements. Other comments raised several concerns about the privacy and security of consumers' personally identifiable information, particularly citizenship and immigration status, and asked HHS to clarify how these entities would collect, store, and use PII. Some commenters wanted HHS to clarify that web-based entities will not gather and store data beyond that necessary for the Federal platform, State-based Exchanges, and Medicaid eligibility and enrollment via ''cookies'' or other tracking tools, and would not store or use information gathered from consumers in the application process for marketing other products.

Response: We agree that implementing the proposal will be a significant undertaking for HHS, and that privacy and security risks must be addressed prior to implementation. We intend for the standards outlined in this section to provide a framework to prepare for the implementation to support use of the enhanced direct enrollment option in future years. We will continue to consider commenters' recommendations on ensuring consumers are protected, and intend to propose further protections in future rulemaking.

d. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

We proposed to amend § 156.270(d) to specify that a QHP issuer must provide a 3-month grace period to an enrollee who, upon failing to timely pay his or her premiums, is receiving advance payments of the premium tax credit. Because we believe that changing the length of an enrollee's grace period during the middle of the grace period would be confusing to enrollees and could result in otherwise avoidable terminations for failure to pay premiums, enrollees receiving APTC who enter a grace period for failing to timely pay premiums and who also lose their eligibility for APTC for any reason during the grace period would be able to complete the remaining portion of the grace period as though the loss of eligibility for APTC did not occur. Although the length of the grace period would continue as though the loss of eligibility for APTC did not occur, payment of APTC would terminate through normal Exchange operations as a result of the loss of eligibility. The proposed amendment to § 156.270(d) also would eliminate language limiting the 3-month grace period for enrollees who are receiving APTC to only those enrollees who made a payment during the benefit year. This would permit enrollees renewing coverage that does not require a binder payment who fail to pay January premiums in full (or fail to pay within an issuer's premium payment threshold policy, if applicable) to receive the full grace period of 3 months. This change would align more closely with our interpretation of the interaction between grace periods, guaranteed availability and renewability, and the binder payment requirement, that a binder payment is

not necessary when an enrollee enrolls, either actively or passively, in a plan within the same insurance product, and would prevent enrollees who re-enroll in the same plan or product from unfairly losing their right to a grace period because they do not make a payment for January coverage. Finally, we proposed to codify with regard to the grace period standards our policy described in the preamble for § 155.400 of this part that if an enrollee receiving advance payments of the premium tax credit can satisfy the requirement to pay all outstanding premiums, or if the enrollee satisfies an issuer's premium payment threshold implemented under § 155.400(g), if applicable, the QHP issuer must not terminate for non-payment of premium the enrollee's enrollment through the Exchange. This change to the rule would reflect the extension of the premium threshold policy to enrollees who are in a grace period for non-payment of premium.

Comment: Many commenters supported the proposed rule because it offers an important consumer protection and reduces confusion about the length of an enrollee's grace period if the enrollee had his or her APTC adjusted to $0 during the 3-month grace period for enrollees receiving APTC. Several commenters, however, stated that the proposed rule would cause providers to bear the burden of claims, subsequently reversed by issuers, incurred during the second and third months of a grace period for enrollees receiving APTC. Some, opposing the proposed rule, preferred that enrollees losing their APTC during a 3-month grace period revert to State rules to determine the length of the remainder of the grace period. Several other commenters approved of the proposed rule so long as providers were guaranteed to be reimbursed for claims incurred during the second and third months of the 3-month grace period. Finally, several commenters offered suggestions relating to enhancing the requirement contained in § 156.270(d)(3) that issuers notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

Response: We recognize that the proposed rule could allow for claims to be submitted and pended during the second and third months of a grace period that, absent this amendment to the rule, would have been disallowed for lack of coverage if the length of the enrollee's remaining grace period had been shorter under State rules. However, the proposed standard is consistent with our current rules, and because of the importance we attach to the consumer protection inherent in the proposed rule, we are finalizing the proposal as proposed.

Comment: One commenter requested clarification that non-payment of a binder payment would not give rise to a grace period under the proposed rule. Other commenters requested clarification that, under the proposed rule, an enrollee is not eligible to receive a 3-month grace period for non-payment of premium for a plan which is not being paid, at least in part, by APTC. One commenter requested that, due to the complexity of creating the systems operations necessary to implement the rule, the proposed rule not go into effect, until after the date it is finalized.

Response: The changes to § 156.270(d) do not conflict with or change the binder payment rule at § 155.400(e), which states that Exchanges may, and the Federally-facilitated Exchange will, require payment of the first month's premium to effectuate an enrollment. Likewise, the changes to the binder payment rule at § 155.400(e) do not eliminate the need for an enrollee to pay a binder payment to effectuate coverage. The rule also does not change the existing rule that an enrollee is not eligible to receive a 3-month grace period for non-payment of premium for a plan which is not being paid, at least in part, by APTC. Similarly, the rule does not make any change to the rules related to the gain or loss of APTC. As with the other parts of this rule, the amendments to § 156.270(d) would be effective only after the effective date, identified at the beginning of this rule.

Comment: While some commenters expressed support for the codification of our interpretation that our rules do not require a binder payment when an enrollee enrolls, either actively or passively, in a plan within the same insurance product (but does require a binder payment when a consumer enrolls in a new product or with a new issuer), several commenters raised objections to the proposed rule's amendment of § 156.270(d) to eliminate language limiting the 3-month grace period for enrollees who are receiving APTC to only those enrollees who made a payment during the benefit year. Some commenters stated that such a change would have an adverse actuarial effect on the risk pool, and encourage enrollees to neglect their premium payments in favor of receiving free coverage during the 3-month grace period for enrollees receiving APTC.

Response: We do not interpret our rules to require a binder payment for re-enrollment from an enrollee who is enrolling with the same issuer in the same plan or product. We characterize such a re-enrollment as a renewal of coverage, which, according to our interpretation of our rules, is treated the same as a regularly-billed monthly premium payment. Because a binder payment is not required by our rules in such circumstances, we do not believe that an enrollee receiving APTC who is re-enrolling, either actively or passively, into the same plan or product should be denied a 3-month grace period if he or she does not make full payment (or a payment within the issuer's premium payment threshold, if any) for January of a benefit year. Additionally, we do not believe that this causes actuarial risk to the coverage pool or an enticement to game the system any more than such dangers would exist during any other part of the benefit year. Because we believe that this amendment offers an important consumer protection, we are finalizing the proposed rule as written. At the same time, we will carefully monitor consumer use of grace periods and make any necessary changes in future rules or guidance.

e. Additional Standards Specific to SHOP (§ 156.285)

In § 156.285(c)(5), we proposed to specify additional details about how a QHP issuer offering a QHP through an FF–SHOP should reconcile enrollment files with the FF–SHOP. Issuers would be required to send enrollment reconciliation files on at least a monthly basis according to a process and timeline established by the FF–SHOP, and in a file format specified by the FF–SHOP.

We also proposed to delete § 156.285(d)(2), to be consistent with our interpretation of guaranteed availability and guaranteed renewability. We specifically proposed that if a qualified employer withdraws from a SHOP, the SHOP, not the issuer should terminate the group's enrollment through the SHOP, and coverage might in many circumstances continue outside the SHOP.

We received no comments on these proposals. We are finalizing the amendment to delete § 156.285(d)(2) as proposed, and are finalizing the amendment to § 156.285(c)(5) with modifications to clarify that a general requirement under this provision still appliesin all SHOPs and to delete the word ''must'' because it is superfluous in light of the introductory language in § 156.285(c).

f. Meaningful Difference Standard for Qualified Health Plans in the Federally-Facilitated Exchanges (§ 156.298)

At § 156.298, we proposed modifications to the meaningful difference standard for QHPs in the FFEs. We proposed to remove the criterion in paragraph (b)(5) that otherwise identical plans would be considered meaningfully different on the basis of one QHP being health savings account (HSA) eligible. We also proposed to delete ''self-only'' and ''non-self-only'' from paragraph (b)(6). We further proposed to redesignate paragraph (b)(6) as paragraph (b)(5) and add the word ''or'' to paragraph (b)(4).

Comment: Commenters generally supported the removal of HSA eligibility as a criterion for determining meaningful difference from otherwise identical plans, so long as standard key differences in how the deductible applies will be accounted for in the existing cost sharing meaningful difference standard at § 156.298(b)(1). One commenter noted that it is important that HHS permit an issuer to offer different QHPs that look similar in terms of deductible and copayments, where one is HSA-compatible but the other is not, because certain services may be covered without a deductible.

Response: We have determined that HSA eligibility is a cost-sharing status that may be assessed by examining the QHP's cost sharing, which is included at paragraph (b)(1) and that the ''Health Savings Account eligibility'' criterion is therefore redundant.

Comment: Commenters also generally supported removing the self-only and non self-only criteria and questioned why the ''child-only'' status was retained.

Response: We are finalizing the removal of the self-only and non self-only criteria. Self-only (that is, individual) plans do not allow any dependent relationships, while non-self-only (that is, enrollee group or family) plans allow at least one dependent relationship type. An individual can enroll in individual and family plans. The allowance of dependents is the only difference between two plans if they are identified as individual only or family. These statuses alone are not indicative of meaningful differences among QHPs.

We will maintain the ''child-only'' versus non-child-only status. It is permissible for QHP issuers to offer child-only plans in which the only enrollees are individuals who have not attained the age of 21. We believe that such a child-only plan would be meaningfully different from a non child-only plan.

Comment: Several commenters asked that HHS consider other ways to strengthen meaningful difference standards, such as by adding additional quantitative standards.

Response: We are not proposing any additional meaningful difference standards at this time, but will continue to review the implementation of this policy over time.

g. Other Considerations

We reminded issuers that certain other Federal civil rights laws impose non-discrimination requirements. Issuers that receive Federal financial assistance, including in connection with offering a QHP on an Exchange, are subject to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973, and section 1557 of the Affordable Care Act. The Office for Civil Rights (OCR), which enforces these statutes, published a notice of proposed rulemaking on September 9, 2015 (80 FR 54172) on the requirements of section 1557. Issuers that intend to seek certification of one or more QHPs are directed to that proposed rule and to *http://www.hhs.gov/ocr/civilrights* for additional information.

We also sought comments on fostering market-driven programs that can improve the management of costs and care. We noted that innovative issuer, provider, and local programs or strategies may be successful in promoting and managing care, potentially resulting in better health outcomes and lower rates while creating important differentiation opportunities for market participants. We sought comment on ways in which we can facilitate such innovation, and in particular on whether there are regulations or policies in place that we should modify in order to foster this innovation.

Comment: A few commenters stated that the exclusion of quality improvement activities in the MLR definition (for example, drug utilization review programs, and value-based oncology management programs) deters issuers from pursuing such innovative programs. Commenters recommended HHS revise the MLR numerator definition to include the costs of such programs.

A few commenters also suggested that HHS revisit last year's requirements requiring issuers to cover the greater of one drug in every USP category and class, or the same number of prescription drugs in each category and class as the EHB-benchmark, and also establishing P&T committees. Commenters stated that the administrative expense is significant and unnecessary.

One commenter also asked HHS to reconsider the mail order and specialty pharmacy restrictions in the 2016 final Payment Notice (§ 156.122(e) and (d)) starting for the 2017 benefit year, and instead establish less restrictive methods to achieve its policy goals, for example by requiring issuers and their prescription benefit managers (PBMs) to establish protocols that facilitate mail order delivery to enrollees with transitional living situations, multiple addresses, or other living arrangements requiring non-standard delivery. The commenter suggested that HHS could require that any mandatory mail order programs offered only apply to maintenance medications and only after a first fill of a new medication, as is common in the marketplace.

We received a comment stating that any willing provider laws can prevent selective contracting between issuers and providers as any willing provider that accepts the issuers' terms is considered in-network. The commenter stated that HHS should take into account the negative impact of such restrictions on innovation and avoid imposing similar regulatory impediments on issuers participating in the Exchange. Another commenter urged HHS to focus on addressing true drivers of costs, and avoid putting all financial responsibility on consumers. The commenter stated that consumer-based programs like reference pricing and benefit design structures are difficult for consumers to understand, particularly for those with low income literacy. Additionally, the commenter suggested addressing utilization of more evidence-based care with incentives for providers, and the need for broader efforts on price variation. Another comment requested HHS develop tools to allow consumers to pick plans based on quality and cost-effectiveness, adopt policies to increase transparency in costs (public reporting on costs for episodes), promote technology-enabled care delivery, and adopt policies to encourage total community health. We received one comment requesting that HHS not require SADPs to offer plans within its three categories (routine, basic and major), as it results in inaccurate plan representation and consumer confusion.

Another commenter suggested HHS explore options to waive the Medicaid rebate program, specifically the best price restriction, under which the Exchange QHP drug prices are included. This sets a pricing floor and prevents PBMs from negotiating lower drug prices or manufacturer rebates.

Response: We appreciate these comments and will consider them for future rulemaking.

6. Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform (§ 156.350)

To make it operationally feasible for a State-based Exchange to rely on the Federal platform for eligibility and enrollment functions, issuers and plans offered on the SBE–FP must comply with rules, as interpreted and implemented in policy and guidance related to the Federal eligibility and enrollment infrastructure. These would be the same requirements related to eligibility and enrollment that are applicable to QHP issuers and plans on FFEs. For example, SBE–FP special enrollment periods must be administered within the guidelines of the FFE special enrollment periods, as it is not possible at this time for the Federal platform to accommodate State customization in policy or operations, such as State-specific special enrollment periods, application questions, display elements in plan compare, or data analysis. Additionally, if the Federal platform is to perform eligibility and enrollment functions, the Federal platform would also need to provide for certain consumer tools (for example, plan compare, premium estimator, second-lowest cost silver plan tool) to support those functions. Thus, the Federal platform would need SBE–FP QHP plan data by the dates specified in the annual Letter to Issuers to provide for adequate testing and loading of the data into the various consumer tools the FFEs offer. Issuers must also comply with certain FFE enrollment policies and operations (for example, premium payment and grace period rules, effective date logic, acceptable transaction codes, and reconciliation rules) for the Federal platform to successfully process 834 transactions with issuers and minimize any data discrepancies for reconciliation.

Therefore, we proposed to add § 156.350 to address eligibility and enrollment standards for QHP issuers participating on an SBE–FP. In paragraph (a) of new § 156.350, we proposed that QHP issuers participating in an SBE–FP must comply with HHS regulations, and guidance related to the eligibility and enrollment functions for which the State-based Exchange relies on the Federal platform. For example, those issuers would be required to comply with operational standards in the Federally-facilitated Exchange and Federally-facilitated Small Business Health Options Program Enrollment Manual. We proposed in paragraph (a) a list of provisions with which QHP issuers participating in an SBE–FP would be required to comply. These provisions relate to eligibility and enrollment functions directly, or are critical to enabling HHS to assess compliance with eligibility and enrollment functions. For example, we would require QHP issuers to comply with the requirements regarding compliance reviews of QHP issuers to the extent relating directly to applicable eligibility and enrollment functions. Without this requirement, we would be severely limited in our ability to determine whether an issuer is complying with the requirements related directly to the Federal platform's eligibility and enrollment functions. In paragraph (b), we proposed to permit these issuers to directly enroll applicants in a manner that is considered to be through the Exchange, under § 156.1230, just as QHP issuers on FFEs are permitted.

In paragraph (c), we proposed that if an SBE–FP does not substantially enforce the eligibility and enrollment standards described in paragraph (a), then HHS may enforce against the issuer or plan using the enforcement remedies and processes described in subpart I of part 156. We also proposed that the administrative review process in subpart J of part 156 would apply to enforcement actions taken against QHP issuers or plans under proposed § 156.350. Because timely compliance with paragraph (a) is vital to the smooth functioning of the Federal platform and because the Federal platform would apply a uniform compliance and enforcement regime for reasons of efficiency and speed, we believe it is appropriate that HHS have this authority in this circumstance.

Because this proposal would insert a section applicable to SBE–FPs in subpart D, which currently describes only standards for QHP issuers on the FFEs, we proposed to amend the title of subpart D to read Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform.

Comment: We received comments stating the disadvantages of the Federal platform not being able to accommodate State customization. One commenter requested clarification that if a State elects to use the Federal platform for only the individual market or only for the SHOP market, the State should only be required to comply with the operational standards of the FFE for that market, not both. We also received comments supporting this proposal, noting that for issuers participating in both FFE and SBE–FP States this policy enables streamlined policies across platforms and would decrease operational burden for issuers, enrollees, and Exchanges.

Response: As we discuss above, at this time the Federal platform is not able to accommodate State customization in policy or operations. We are finalizing this policy as proposed. However, we are confirming that there is the flexibility for a State to elect to use the Federal platform for certain functions for either the individual market, or the SHOP market, or both. We are also confirming that should a State elect to use the Federal platform for certain functions for only one market, the requirements in § 156.350 would only apply for the market for which the State elects to rely on the Federal platform.

7. Enforcement Remedies in Federally-Facilitated Exchanges (§§ 156.800, 156.805, and 156.810)

In the proposed rule, we discussed four proposed rule changes. First, we proposed to revise paragraph § 156.805(d) to explain fully the effect of appealing a CMP. In the interest of aligning our CMP and decertification regulations, we proposed to rename paragraph (d) ''Request for hearing.'' We proposed to state affirmatively the issuer's right to file a request for hearing on the assessment of a CMP and we proposed to add language stating that the request for hearing will suspend the assessment of CMP until a final administrative decision on the appeal. This was similar to language in the decertification rule.

Second, we proposed to amend § 156.810 to present the appeal rights of QHP issuers and the impact of an appeal more clearly. Specifically, we added language to explain how an appeal will affect the effective date of a decertification depending on whether the decertification is standard or expedited.

Third, we proposed to remove § 156.800(c), in which we stated that sanctions will not be imposed on a QHP issuer on an FFE if it has made good faith efforts to comply with applicable requirements for calendar years 2014 and 2015. Starting in the 2016 calendar year and beyond, we proposed to impose sanctions on a QHP issuer in an FFE if the issuer fails to comply with applicable standards, even if the QHP issuer has made good faith efforts to comply with these requirements. We intend to use a progressive compliance model for determining sanctions.

Fourth, we proposed to add new bases for decertification of a QHP to § 156.810. One of the bases for decertification, § 156.810(a)(5), authorizes decertification if a QHP issuer is hindering the efficient and effective operation of a Federally-facilitated Exchange. We explained our intent to interpret hindering the efficient and effective operation of the FFEs to include impeding displaying plans properly to enrollees who purchase coverage under that plan. Where an issuer has informed HHS that it cannot continue to provide coverage under a QHP, HHS will interpret this information to mean that the efficient and effective operation of the FFE will be hindered because it will incorrectly display plans on the FFE platform. In such a case, we proposed to take all necessary steps to suppress or decertify the QHP.

We also proposed to add a basis for decertification to § 156.810 to address situations where a QHP issuer is the subject of a pending or existing State enforcement action, including a consent order, or where HHS has reasonably determined that an issuer lacks the funds to continue providing coverage to its consumers for the remainder of the plan year. Under its obligation to determine that making a plan available on the FFEs is in the interest of qualified individuals and employers, we proposed to adopt these decertification bases as a consumer protection measure.

We invited comments from affected parties on the proposal to end the good faith compliance policy and on the proposed bases for decertification.

Comment: We received comments requesting that we extend the good faith compliance policy into 2016. Some commenters only asked for an extension of the good faith compliance policy for new 2016 requirements. Commenters also requested that we clarify that any conduct occurring in 2014 and 2015 remain subject to the good faith compliance policy in the future. Others requested that, if the policy ended, we use a progressive compliance model for any compliance enforcement in the future. One commenter supported ending the policy.

Response: We are not extending § 156.800(c) to cover calendar year 2016. While there are new requirements for issuers in 2016, we believe that issuers have had sufficient time to acquaint themselves with how to comply with the fundamental regulations underpinning participation in the FFEs. We will be using a progressive compliance model for compliance conduct in the future, and may evaluate how new a particular requirement is when determining the appropriate enforcement remedy. We believe, based on past and current compliance monitoring and enforcement efforts, that issuers have gained enough experience with the FFEs to comply fully with participation standards. Of course, in all our enforcement actions, we will continue to take into account all facts and circumstances, including the reasonable good faith action of issuers.

Comment: We received comments that the expansion of bases for decertification, especially a basis for decertification based on financial solvency, falls under State, not Federal authority. One commenter expressed support for the expanded bases for decertification.

Response: We are finalizing the regulation as proposed. We believe that the added bases are necessary to provide consumers a consistent and reliable coverage experience through the FFEs. We do not believe this constitutes any infringement on State authority. While State regulators do have primary authority over whether issuers may sell coverage within the State, issuers must also comply with Federal requirements for participation in the FFEs and avoid conduct that violates Federal standards for decertification if they wish to sell QHPs on an FFE. When HHS reasonably determines, in coordination with information received from State regulators, that the issuer lacks the financial ability to provide coverage until the end of the coverage period, HHS must be able to take action to protect FFE consumers. Any action for consumers not enrolled in a QHP on an FFE generally remains the primary authority of the State regulator and outside the influence of these regulations.

8. Quality Standards

a. Patient Safety Standards for QHP Issuers (§ 156.1110)

In the proposed rule, we proposed to strengthen QHP patient safety standards at § 156.1110 in accordance with section 1311(h) of the Affordable Care Act for plan years beginning on or after January 1, 2017. We noted the importance of alignment of the QHP issuer standards with effective patient safety interventions and leveraging the successful work already being done at national, regional, and local hospital systems for health care quality improvement and harm reduction to achieve greater impact on reducing patient harm. We proposed amending § 156.1110 to capture the current patient safety standards that continue to apply for plan years beginning before January 1, 2017 in new paragraph (a)(1). We also proposed to add new paragraph (a)(2)(i)(A) to specify that for plan years beginning on or after January 1, 2017, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital uses a patient safety evaluation system as defined in 42 CFR 3.20. We proposed to require, under new paragraph (a)(2)(i)(B), that for plan years beginning on or after January 1, 2017 a QHP issuer that contracts with a hospital with greater than 50 beds must ensure that the hospital implements a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient. We noted that use of a data-driven approach, analytic feedback, and shared learning to advance patient safety, such as working with a Patient Safety Organization (PSO), are essential to implementing meaningful interventions to improve patient health care quality.

We also proposed to exercise the authority provided to the Secretary under section 1311(h)(2) of the Affordable Care Act to establish reasonable exceptions to the QHP issuer patient safety requirements. Specifically, in new paragraph (a)(2)(ii), for plan years beginning on or after January 1, 2017, QHP issuers can verify that a contracted hospital with greater than 50 beds implements evidence-based initiatives to reduce all cause preventable harm,[60] prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events by a means other than reporting of such information to a PSO. We noted that this would allow flexibility and promote alignment for hospitals that already engage in effective national, State, public and private patient safety programs.

We proposed to amend the documentation requirement for plan years beginning on or after January 1, 2017, from the collection of the hospital's CMS Certification Number to materials which reflect implementation of PSO activities, such as documentation of PSOs and hospitals working together to collect, report and

[60] All cause preventable harm or all adverse events-any event during the care process that results in harm to a patient, regardless of cause (Letter from Center for Clinical Standards and Quality/Survey & Certification Group to State Survey Agency Directors regarding AHRQ Common Formats—Information for Hospitals and State Survey Agencies (SAs)—Comprehensive Patient Safety Reporting Using AHRQ Common Formats (Mar. 15, 2013), available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf*).

analyze patient safety events, and implementation of a comprehensive person-centered hospital discharge program to demonstrate compliance with the proposed requirements in § 156.1110(a)(2)(i); or documentation to reflect implementation of other patient safety initiatives to reduce all cause preventable harm, prevent hospital readmission, improve care coordination and improve health care quality through the collection, management and analysis of patient safety events to demonstrate compliance with the reasonable exception provision proposed to be captured in § 156.1110(a)(2)(ii).

We noted that we were considering providing that QHP issuers must ensure that their contracted hospitals as described in section 1311(h) are standardizing reporting of patient safety events with the use of the Agency for Healthcare Research and Quality (AHRQ) Common Formats. We also noted that these proposed standards would leverage the successful work already being done at national, regional, and local hospital systems for health care quality improvement and harm reduction, and align with effective patient safety interventions to achieve greater impact.

We are finalizing these proposals with the following modification. We are modifying the reasonable exceptions provision in § 156.1110(a)(2)(ii) to state that QHP issuers must verify that their applicable contracted hospitals with greater than 50 beds, if not working with a PSO, implement an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events, that reduces all cause preventable harm, prevents hospital readmission or improves care coordination. We acknowledge that some of the patient safety activities that a hospital performs with a PSO may be very similar, if not identical to, some of the activities that hospitals will perform as part of the initiatives described in § 156.1110(a)(2)(ii). If a provider undertakes activities to improve patient safety and health care quality, but does not do so in conjunction with a PSO, subject to the requirements of the Patient Safety and Quality Improvement Act (PSQIA) and its implementing regulation, 42 CFR part 3, the patient safety and quality information involved in such initiatives would not be subject to the PSQIA's privilege and confidentiality protections.

Comment: Most commenters generally supported our proposals and agreed with strengthening QHP issuer patient safety standards. Commenters agreed with HHS's approach of aligning existing, effective patient safety initiatives, including by requiring applicable hospitals to report to PSOs, as well as providing flexibility to allow compliance with § 156.1110 by implementing evidence-based initiatives other than working with a PSO. One commenter stated that the proposal outlined in § 156.1110(a)(2)(i)—to require a QHP issuer that contracts with a hospital with greater than 50 beds to verify that the hospital uses a patient safety evaluation system as defined in 42 CFR 3.20—should be the preferred option versus establishing reasonable exceptions in the proposed requirement in § 156.1110(a)(2)(ii). The commenter strongly supported reporting to a patient safety evaluation system because most PSOs collect all types of information from all types of health care organizations, unlike Hospital Engagement Networks (HENs) initiatives and Quality Improvement Organizations (QIOs) commissioned work, which are typically focused on certain conditions or topics. The commenter also stated that requiring hospital providers to contract with a Federally-listed PSO would decrease QHP operational burden and expenses versus the QHP burden of keeping track of multiple organizations and HEN patient safety initiatives with tenuous, variable funding.

Response: We agree with the majority of commenters and are finalizing the proposed approach of requiring QHP issuers, for plan years beginning on or after January 1, 2017 to verify that their contracted hospitals, with more than 50 beds, have current agreements with PSOs, while also providing reasonable exceptions to the PSO requirement. We believe that these requirements allow for increased alignment of QHP issuer standards with effective patient safety interventions. We agree that PSOs collect and analyze valuable information through patient safety evaluation systems to reduce harm and we believe that the requirements finalized in § 156.1110 for plan years beginning on or after January 1, 2017, will allow for both flexibility and innovation for hospitals to choose the most relevant patient safety initiative for their populations. We believe hospitals may choose to work with a PSO as their preferred option. We acknowledge that the different initiatives mentioned in the proposed rule, including HENs, QIOs and PSOs, may work on focused topic areas to reduce patient harm. Therefore, we believe that it is important for hospitals and their partners to determine and engage in the appropriate strategies reflecting the needs of their respective patient populations.

Comment: One commenter requested that HHS amend the proposed regulatory language in § 156.1110(a)(2)(ii) because it would be difficult to find any single patient safety initiative that addresses the reduction of all cause preventable harm,[61] prevention of hospital readmission, improved care coordination and improved health care quality through the collection, management and analysis of patient safety events, as currently proposed.

Response: We are finalizing the proposed requirement at § 156.1110(a)(2)(ii), with one modification. We are modifying the reasonable exceptions provision to state that for plan years beginning on or after January 1, 2017, QHP issuers must verify that their contracted hospitals with greater than 50 beds, if not working with a PSO, implement an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission or improves care coordination. We clarify that the evidence-based initiatives described in this reasonable exception provision are not intended to address all aspects of all-cause preventable harm, hospital readmission, care coordination, and health care quality in one single initiative.

Comment: Several commenters requested that HHS recognize State-level patient safety reporting programs, such as the mandatory Patient Safety Reporting System required in Pennsylvania, and Maine's Sentinel Event Reporting Program. Commenters noted that these State-level reporting programs are robust, evidence-based, effective patient safety programs that have delivered high value and improved patient safety across their regions. They recommended granting such exceptions because reporting to a PSO or other entity would be burdensome, duplicative, and would not align with reporting by hospitals in those States.

[61] All cause preventable harm or all adverse events—any event during the care process that results in harm to a patient, regardless of cause (Letter from Center for Clinical Standards and Quality/Survey & Certification Group to State Survey Agency Directors regarding AHRQ Common Formats—Information for Hospitals and State Survey Agencies (SAs)—Comprehensive Patient Safety Reporting Using AHRQ Common Formats (Mar. 15, 2013), available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf*).

Response: We acknowledge that there could be local, State, or national patient safety reporting programs that meet or exceed the patient safety standards for plan years beginning on or after January 1, 2017, as outlined in § 156.1110(a)(2). Therefore, the QHP issuer patient safety requirements are intended to be broad and inclusive of various initiatives, such as State-level, evidence-based programs that improve health care quality through the collection, management and analysis of patient safety events, and that reduce all cause preventable harm, prevent hospital readmission, or improve care coordination. We describe, in the reasonable exceptions provision finalized at § 156.1110(a)(2)(ii), the key concepts characterizing an evidence-based patient safety initiative that are consistent with the National Quality Strategy and existing public and private patient safety programs. However, we do not intend to provide an exhaustive list of initiatives, to allow for flexibility and innovation for future advances in patient safety.

Comment: A few commenters suggested amending the proposed documentation requirement outlined in § 156.1110(b), and recommended allowing hospitals to attest that they participate in a patient safety activity to minimize the documentation requirement and ensure efficient, consistent mechanisms for compliance by hospitals.

Response: We maintain the documentation requirement as outlined in § 156.1110(b) and clarify that we intend the requirement for plan years beginning on or after January 1, 2017, to be broad and inclusive of examples such as hospital attestations or current agreements to partner with a PSO, HEN, or QIO. We believe that the patient safety standards support a common goal of preventing the risk of patient harm in an effective, sustainable way. We believe it is important to allow for flexibility regarding methods of complying with the new documentation requirements at § 156.1110(b)(2) in order to balance both issuer and hospital burden and to accommodate a variety of types of patient safety initiatives in which hospitals may engage. We also believe that QHP issuers and their contracted hospitals should have flexibility in how they comply with the documentation requirement as they develop their contracts.

Comment: One commenter did not agree with the proposed documentation requirement to have hospitals share their PSO agreements with QHPs because of concern of violating confidentiality provisions of sharing patient safety work products and analyses outside of the PSO per the PSQIA. Another commenter requested clarification regarding whether HHS would collect and publish data on the patient safety evaluation system as defined in 42 CFR 3.20.

Response: PSO contracts with hospitals for the purpose of receiving and reviewing patient safety work product (referred to as Patient Safety Act contracts) do not meet the definition of ''patient safety work product'', and thus, are not subject to the protections and requirements in the PSO statute and regulations. We do not intend to collect and publish data on the patient safety evaluation system nor are we generally permitted to publish patient safety work product. We clarify that these QHP issuer patient safety requirements are intended to support implementation of the PSQIA and would not violate the confidentiality provisions of patient safety work product, as defined in the PSQIA. We clarify that the QHP issuer documentation requirement in § 156.1110(b)(2) is intended to direct issuers to collect basic, administrative-type information from their contracted hospitals, with greater than 50 beds, to demonstrate compliance with the patient safety requirement for plan years beginning on or after January 1, 2017. For example, we expect such information could include current hospital agreements or attestations to partner with a PSO, which we note would not contain patient safety work product. In addition, we clarify that such information to demonstrate compliance would be submitted to an Exchange, upon request by the Exchange per the established requirement in § 156.1110(c).

Comment: Several commenters requested that HHS consider that the timeframes of hospital patient safety initiatives may not coincide with plan years, and that HHS allow flexibility so that a hospital may attest to the fact that it is already or will start to take part in a patient safety activity during the relevant plan year or base compliance on a hospital's previous year's activities. One commenter urged HHS to build a process for approving new initiatives in the future.

Response: We acknowledge that timeframes of hospital patient safety initiatives may not exactly align with plan years. We are finalizing the patient safety requirement in § 156.1110(a)(2) to state that for plan years beginning on or after January 1, 2017, issuers must verify that their applicable contracted hospitals with greater than 50 beds use a patient safety evaluation system as defined in 42 CFR 3.20, as well as implement a mechanism for comprehensive hospital discharge to improve care coordination and quality or implement an alternative evidence-based initiative. We clarify that we do not specify dates of activity regarding patient safety initiatives because we believe it is the responsibility of the issuer and contracted hospital to maintain current documentation and ensure compliance with these patient safety standards.

Comment: Several commenters supported the proposed discharge planning requirements outlined in § 156.1110(a)(2)(i)(B) that states that a QHP issuer that contracts with a hospital with greater than 50 beds must ensure that the hospital implemented a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient. Commenters expressed that it is critical that the discharge planning process reflect the needs of all populations and sub-populations. Some commenters noted that HHS is already addressing hospital discharge planning requirements in a separate proposed rule, CMS 3377–P (80 FR 68125 (Nov. 3, 2015)), which should be used to meet the discharge requirements in section 1311(h) of the Affordable Care Act and to minimize unnecessary burden on QHP issuers and hospitals.

Response: We acknowledge that HHS has currently proposed implementing discharge planning requirements mandated in section 1899B(i) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, Pub. L. 113–185) by modifying the discharge planning or discharge summary Condition of Participation requirements for hospitals. We agree with aligning discharge planning requirements to minimize burden, and clarify that continued collection of CMS Certification Numbers (CCNs) would be sufficient for issuers to comply with § 156.1110(a)(2)(i)(B). We believe there would be no additional burden because QHP issuers have already been collecting this documentation since January 1, 2015, for the initial phase of the QHP issuer patient safety standards. We are finalizing the documentation requirement in § 156.1110(b)(2) for plan years beginning on or after January 1, 2017 and clarify that the information to be collected by a QHP issuer could include CCNs to demonstrate that their contracted hospitals implement mechanisms for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient. We also believe it is important to provide flexibility to hospitals and QHP issuers and note that

other types of information may be collected to demonstrate compliance with comprehensive person-centered hospital discharge if hospitals choose to implement this in alternative ways, other than meeting Condition of Participation requirements.

Comment: Many commenters did not support mandating the use of AHRQ Common Formats for standardizing reporting of patient safety events. They stated that requiring use of Common Formats would stifle private sector innovation and investment in the development of PSOs, would add burden and costs to PSO formation, and could cause existing PSOs to voluntary delist. Some commenters noted that hospitals that already report patient safety data in a standardized manner through other reporting systems that meet or exceed the Patient Safety and Quality Improvement Act requirements, would incur undue burden as well. Commenters urged HHS to allow flexibility to PSOs and their participants to choose the reporting format or tool they use to submit patient safety event data.

Response: We continue to strongly support hospital tracking of patient safety events using the AHRQ Common Formats,[62] which are a useful tool for a hospital regardless of what patient safety interventions are implemented for ongoing, data-driven quality assessment. We also note that use of Common Formats, and aligning with existing HHS recommendations for hospitals,[63] is integral, whether a hospital chooses to work with a PSO to comply with the proposed requirement in § 156.1110(a)(2)(i), or implements an alternative approach under the reasonable exception provision in § 156.1110(a)(2)(ii). We also remind PSOs of their requirement to collect patient safety work product in a standardized manner, as set forth in 42 CFR 3.102(b)(2)(i)(F) and (b)(2)(iii). However, we clarify that the QHP issuer patient safety standards finalized in this rule do not require the use of the Common Formats for patient safety event reporting at this time.

Comment: A few commenters provided recommendations regarding the requirement to collect and maintain CCNs and to establish quality improvement strategies.

Response: We clarify that we are finalizing requirements to transition from the first phase of patient safety standards that required, beginning on January 1, 2015, QHP issuers to verify that certain contracted hospitals meet Medicare Hospital Conditions of Participation requirements regarding a quality assessment and performance improvement program and a discharge planning process. In other words, we are finalizing the amendments to § 156.1110 to begin the second phase of the patient safety standards to require for plan years beginning on January 1, 2017, QHP issuers to verify that their contracted hospitals with greater than 50 beds use a patient safety evaluation system as defined in 42 CFR 3.20, and implement a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient; or implement an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination by a means other than reporting of such information to or by a PSO. We clarify that the collection of CCNs would be sufficient under § 156.1110(b)(2) for QHP issuers to document compliance with § 156.1110(a)(2)(i)(B).

We also note that QHP issuer requirements relating to quality improvement strategies were established in the 2016 Payment Notice (80 FR 10844); therefore, comments specific to QHP issuer implementation and reporting of quality improvement strategies are out of scope of this rule. However, we expect QHP issuers would align and coordinate implementation of their contracted hospital patient safety initiatives with their QHP quality improvement strategies if applicable.

Comment: Several commenters requested clarifications regarding the timeframe for the effective date for data collection to ensure that hospitals have sufficient time to comply with the standards. One commenter suggested one year from the date of the final rule as the effective date of data collection since hospitals would need considerable time to implement activities to comply with these patient safety standards. One commenter requested more detail about how hospitals that meet the standard can be prospectively identified by plans, consumers and regulators.

Response: We believe that the majority of hospitals with greater than 50 beds already partner with a PSO, or implement an alternative national, State, public, or private evidence-based patient safety initiative that uses the collection, management and analysis of patient safety events to reduce all cause preventable harm, prevent hospital readmission, or improve care coordination. We believe that there is an adequate amount of time from the publication of this final rule for QHP issuers and their contracted hospitals to be able to comply with these patient safety standards for plan years beginning on or after January 1, 2017. We expect that issuers would continue their efforts to prospectively identify hospitals to contract with that meet all applicable Federal and State health care quality and safety requirements.

Comment: One commenter requested clarifications regarding the regulatory reference for ''a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient'' and how this is tracked or published.

Response: The language being finalized at § 156.1110(a)(2)(i)(B) implements the patient safety standard captured at section 1311(h)(1)(A)(ii) of the Affordable Care Act, which refers to a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement. We do not intend to track or publish patient safety event data regarding hospital discharge programs at this time. Instead, § 156.1110(b)(2) requires QHP issuers, for plan years beginning on or after January 1, 2017, to collect and maintain documentation to demonstrate that its contracted hospitals with greater than 50 beds meet the required patient safety standards. We also clarify that documentation to demonstrate compliance with the discharge planning requirement (for example, the hospital's CCN) would be submitted to an Exchange, upon request by the Exchange per the established requirement in § 156.1110(c).

9. Qualified Health Plan Issuer Responsibilities

a. Payment and Collections Processes (§ 156.1215)

In the 2015 Payment Notice, HHS established a monthly payment and collections cycle for insurance affordability programs, user fees, and premium stabilization programs. In 2017, as discussed elsewhere in this document, we are finalizing our proposal to charge issuers in SBE–FPs for eligibility and enrollment services a

[62] *https://www.pso.ahrq.gov/common.*

[63] Letter from Center for Clinical Standards and Quality/Survey & Certification Group to State Survey Agency Directors regarding AHRQ Common Formats—Information for Hospitals and State Survey Agencies (SAs)—Comprehensive Patient Safety Reporting Using AHRQ Common Formats (Mar. 15, 2013), available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf.*

user fee for the benefits issuers in SBE–FPs will receive as a result of the SBE–FP's reliance on the Federal platform. To streamline our payment and collections process, we proposed that, for 2017 and later years, for purposes of the netting process, the reference to FFE user fees in § 156.1215(b) would be interpreted to include any fees for issuers in State-based Exchanges using the Federal platform.

In the 2015 Payment Notice, we established in § 156.1215(c) that any amount owed to the Federal government by an issuer and its affiliates is the basis for calculating a debt owed to the Federal government. In this rulemaking, we proposed that, for 2017 and later years, for purposes of calculating the debt owed to the Federal government, we would interpret the reference to FFE user fees to include any fees for issuers in State-based Exchanges using the Federal platform. We also sought comment on whether the regulations should be amended to reflect these interpretations.

We are adopting the interpretations of § 156.1215 we announced in the proposed rule by finalizing conforming amendments to paragraphs (b) and (c) of § 156.1215.

Comment: We received one comment on these proposals requesting that HHS clarify if it intends to collect user fees from issuers in State-based Exchanges using the Federal platform beginning in 2015.

Response: Our intent in this section was to establish our authority to collect the user fee from SBE–FP issuers through netting, but only once such a fee has been established. As described elsewhere in this rule, HHS will begin assessing the user fee on issuers in State-based Exchanges using the Federal platform beginning with plan years that start on or after January 1, 2017, or, at the State's request, collecting an equivalent amount from the State. We are finalizing our proposal that, for purposes of the netting process and calculating the debt owed to the Federal government, we will interpret the reference to FFE user fees at § 156.1215(b) and (c) to include any fees for issuers in SBE–FPs, beginning with plan years that start on or after January 1, 2017.

b. Administrative Appeals (§ 156.1220)

In the 2015 Payment Notice (79 FR 13818), we established an administrative appeals process for issuers. We established a three-tiered appeals process: a request for reconsideration under § 156.1220(a); a request for an informal hearing before a CMS hearing officer under § 156.1220(b); and a request for review by the Administrator of CMS under § 156.1220(c). In light of HHS's finalization of the proposal around SBE–FPs, we interpret this administrative appeals process to also apply to user fee payments that we collect from SBE–FP QHP issuers that offer plans on an SBE–FP.

Under § 156.1220(a), an issuer may only file a request for reconsideration based on the following: A processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error. For example, an issuer may file a request for reconsideration that challenges the assessment of a default risk adjustment charge if the issuer believes the default charge was assessed because HHS incorrectly applied its methodology regarding data quantity and quality standards set forth in § 153.710(f); however, the issuer may not file a request for reconsideration to challenge the methodology itself. We also clarify that an issuer may not file a request for reconsideration regarding issues arising from the issuer's failure to load complete and accurate data to its dedicated distributed data environment within the data submission window. Errors by the issuer are not appealable.

In line with our proposal to delete § 153.710(d), we proposed to make conforming amendments to modify § 156.1220 to remove cross-references to the interim discrepancy reporting process. Under § 156.1220(a)(4)(ii), a reconsideration relating to risk adjustment or reinsurance may only be requested if, to the extent the issue could have been previously identified by the issuer to HHS under the final discrepancy reporting process proposed to be redesignated at § 153.710(d)(2), it was so identified and remains unresolved. As proposed to be redesignated, § 153.710(d)(2) states that an issuer must identify to HHS any discrepancies it identified in the final distributed data environment reports. We clarify that issuers may identify issues during the discrepancy reporting process under newly designated § 153.710(d)(2) that are not subject to appeal; that is, issuers may identify issues that are not processing errors by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical errors. We clarify that, in contrast, an issuer may only request a reconsideration of unresolved issues that were identified (if they could have been so identified) under the final discrepancy reporting process proposed to be redesignated at § 153.710(d)(2), if contesting a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error. We also clarified that the existence of an unresolved discrepancy is not alone a sufficient basis on which to request a reconsideration.

Additionally, we clarified the grounds for appeals related to the risk corridors program. An issuer may not file a request for reconsideration to challenge the standards for the risk corridors program, including those established in §§ 153.500 through 153.540 and in guidance issued by HHS. In addition, appeals related to data for programs other than risk corridors covered in § 156.1220(a) cannot be grounds for risk corridors appeals. We proposed to clarify that the last submission of data to which the issuer has attested serves as the notification for purposes of § 153.510(d).

We also proposed to shorten the deadline for filing a request for reconsideration in § 156.1220(a)(3) from 60 to 30 calendar days.

Additionally, we proposed to clarify that an issuer must pay the full amount owed to HHS as set forth in the applicable notification, even if the issuer files a request for reconsideration under § 156.1220. Failure to pay an amount owed will result in interest accruing after the applicable payment deadline. Therefore, if an appeal is unsuccessful, and the issuer has not already remitted the charge amount owed, the issuer would owe the debt plus the interest, and administrative fees which accrue from delayed payment. If an appeal is successful, HHS will refund the amount paid in accordance with the final appeal decision. HHS is finalizing this clarification.

We are finalizing our proposal to shorten the timeframe for requesting reconsideration related to the risk adjustment, reinsurance and risk corridors programs to 30 calendar days. This final rule will become effective 60 days after it is published—that is, prior to the June 30 notification of risk adjustment and reinsurance amounts. Therefore, requests for reconsideration related to the risk adjustment, reinsurance and risk corridors programs for the 2015 benefit year must be made within 30 calendar days of notification of the payment or charge. However, HHS will maintain a 60 calendar day timeframe to request reconsideration for the APTC, CSR and user fee programs. Therefore, the request for reconsideration must be filed in accordance with the following timeframes: (1) For the premium tax credit and cost-sharing reduction portions of the advance payments, or

FFE user fee charges, within *60 calendar days* after the date of the final reconsideration notification specifying the aggregate amount of such advance payments or user fees for the applicable benefit year; (2) for a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within *30 calendar days* of the date of the notification under § 153.310(e); (3) for a reinsurance payment, within *30 calendar days* of the date of the notification provided under § 153.240(b)(1)(ii); (4) for a default risk adjustment charge, within *30 calendar days* of the date of the notification of such charge; (5) for reconciliation of the cost-sharing reduction portion of the advance payments, within *60 calendar days* of the date of the notification of such payment or charge; and (6) for a risk corridors payment or charge, within *30 calendar days* of the date of the notification of such payment or charge for the purposes of § 153.510(d). In the proposed rule, we proposed to clarify that the last submission of data to which the issuer has attested serves as the notification for purposes of § 153.510(d). We have since issued a public FAQ stating that for the purposes of the 2014 benefit year the public notification of final estimated risk corridors payments and charge amounts served as the notification for purposes of § 153.510(d).[64]

Comment: One commenter agreed with the shortening the deadline to request reconsideration related to risk adjustment to 30 days from 60 days. Other commenters asked that HHS maintain the 60-day deadline. One commenter requested a 90-day timeline to request reconsideration. Some commenters asked that HHS maintain the longer deadline due to new processes surrounding policy based payments and cost-sharing reductions and advance payments of the premium tax credit reconciliation. Another commenter requested that HHS extend the deadline to file a request for reconsideration to 120 days to allow cost-sharing reductions and advance payments of the premium tax credit adjustments due to the 3-month grace period.

Response: We are finalizing our proposal to shorten the timeframe for requesting reconsideration related to the risk adjustment, reinsurance and risk corridors programs to 30 calendar days. Conversely, HHS will maintain a 60-day deadline to request reconsideration for the APTC, CSR and user fee programs. Finalizing a shorter timeline for the premium stabilization programs requests for reconsideration would permit HHS to resolve administrative appeals, calculate final payments and charges, and make payments in a manner consistent with the reporting and payment timelines for those programs. We agree with commenters that there are several benefits to maintaining the longer 60-day timeframe for the APTC, CSR and user fee programs.

Comment: One commenter asked that HHS pay interest to any issuer who pays and then wins a request for reconsideration.

Response: If an appeal is successful, HHS will issue a refund in accordance with the final appeal decision.

Comment: A few commenters suggested HHS allow unresolved discrepancies to be appealed even if the discrepancy does not fit within one of the three reconsideration basis, otherwise discrepancies could be identified and not resolved within the timeframe without an opportunity for resolution.

Response: Issuers cannot appeal data submission errors that resulted from an issuer error because it is the responsibility of the issuer to submit complete and accurate data (with corrections to any errors) prior to the data submission deadline. Throughout the data collection period, HHS maintains a help desk, hosts user group calls and webinars to assist issuers with the identification and resolution of data submission errors and to provide general technical assistance. Issuers are encouraged to review their data and the EDGE server generated reports, as well as to notify HHS of any problems as soon as possible so that, to the extent feasible, assistance can be provided to resolve those problems before the final data submission deadline. Therefore, HHS will only consider requests for reconsideration related to risk adjustment or reinsurance on the basis that HHS made a processing error, incorrectly applied a relevant methodology, or made a mathematical error. Additionally, HHS would continue to require issuers to identify issues through the final formal discrepancy reporting process, if the issue is identifiable at the time, so HHS can work to address such issues prior to the final risk adjustment transfers and reinsurance payment calculations.

Comment: Some commenters asked that HHS provide a timeline for when requests for reconsideration and appeals will be decided.

Response: HHS understands that receiving a reconsideration decision promptly promotes the timely release of funds, however, due to the varying nature, complexity and number of reconsiderations, HHS cannot set forth a specific deadline. HHS is committed to providing a decision as quickly and efficiently as possible.

c. Third Party Payment of Qualified Health Plan Premiums (§ 156.1250)

We proposed to amend § 156.1250 to clarify that a Federal or State government program includes programs of the political subdivisions of the State, namely counties and municipalities, which we referred to as local governments. Including this clarification in regulations will ensure that States have the flexibility to distribute care and Exchange financial assistance to their vulnerable populations through local governments, consistent with their statutory and regulatory authority.

In terms of the distinction between programs sponsored and operated by the government (such as the Ryan White HIV/AIDS programs) and programs that involve Federal grantees that receive considerable public funding, we acknowledged that programs such as the Ryan White HIV/AIDS program operate by working with cities, States, and local, community-based organizations to provide services in line with their statutory authority. Sections 2604(c)(3)(F), 2612(b)(3)(F), and 2651(c)(3)(F) of the PHS Act authorize Ryan White HIV/AIDS program grantees and sub-grantees to use program funds for premium and cost-sharing assistance. These grantees and sub-grantees must provide the assistance through third-party payments as they are prohibited from making payments directly to patients. Though many Ryan White HIV/AIDS program grantees are State and local governments, not all are; similarly, many of the State and local government grantees administer funds through sub-grantees that are not government entities. We proposed to distinguish government programs from government grantees such that the requirement at § 156.1250 would apply to government programs, but not necessarily to entities that are government grantees, unless specifically authorized and funded by the Federal, State, or local government program to make the payments on behalf of the program, consistent with the government programs' statutory and regulatory authority to provide premium and cost-sharing assistance through grants and grantees. In other words, if such Federal, State, and local governments are authorized to administer their premium and cost-

[64] For the 2014 benefit year, we clarified this deadline in FAQ 14470 (Dec. 21, 2015), available at *https://www.regtap.info.*

sharing assistance through grantees or sub-grantees, the payments may not be rejected on the grounds that they did not come directly from the government programs. In such cases, the source of the Exchange financial assistance is the government program, and administration or distribution of that assistance through grants and grantees is authorized under statute or regulation.

We also proposed to require entities that make third party payments of premiums under this section to notify HHS, in a format and timeline specified in guidance. We proposed that the notification must reflect the entity's intent to make payments of premiums under this section and the number of consumers for whom it intends to make payments.

We also proposed to clarify that while issuers offering individual market QHPs, including SADPs, generally do not collect cost-sharing payments, they are required to accept third party cost-sharing payments on behalf of enrollees in circumstances where the issuer or the issuer's downstream entity accepts cost-sharing payments from plan enrollees. We noted that although cost-sharing payments are generally made to providers, rather than to issuers, there are certain contractual circumstances in which an issuer's non-provider downstream entity engages in activities such as the collection of cost-sharing payments. For example, an issuer's pharmacy benefits manager may collect cost-sharing payments from the issuer's plan enrollees for prescription drugs. We proposed to clarify that in such situations, the rules at § 156.1250 regarding the requirement to accept third-party payments would apply to cost sharing payments.

We noted that we are considering whether to expand the list of entities from whom issuers are required to accept payment under § 156.1250 to include not-for-profit charitable organizations in future years, subject to certain guardrails intended to minimize risk pool impacts, such as limiting assistance to individuals not eligible for other minimum essential coverage and requiring assistance until the end of the calendar year.

Comment: Some commenters expressed concern that the language proposed in § 156.1250(a)(3), ''consistent with the program's statutory authority,'' might be read to require explicit statutory authority to make premium and cost-sharing payments. The commenters stated that such a reading could unduly restrict the ability of some programs to assist clients and cause confusion for both programs and issuers.

Response: We are amending § 156.1250(a) to remove the phrase, ''consistent with the program's statutory authority,'' in order to avoid such confusion. We believe that the phrase, ''directed by a government program to make payments on its behalf,'' is sufficiently specific and clear.

Comment: Several commenters asked that we provide a specific list of entities that qualify as government programs from which third party payments must be accepted. Several other commenters urged that we immediately include not-for-profit, charitable organizations as entities from which third party payments for QHP premiums and cost-sharing must be accepted, with certain guardrails intended to minimize adverse selection. Some of these commenters also urged that HHS provide a list of acceptable foundation types as referenced in HHS's February 7, 2014 FAQ,[65] which stated that the concerns addressed in the November 4, 2013 FAQ[66] do not apply to payments from private, not-for-profit foundations if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status. These commenters expressed that the provision of a list of acceptable foundation types is critical to ensure that these foundations meet the criteria noted in the February 7, 2014 FAQ. Some commenters asked that we collect the following information under our proposed information collection: Number of consumers for whom the entity will be making payments (by State or rating area); volume of payments over a specified time period; contact information; tax ID and filing status; governance (for example, leadership, members of Board of Directors, principal shareholders, etc.); funding sources; information on relationships with provider organizations (financial or other); and information on relationships with pharmaceutical companies (financial or other).

Response: We are not providing a specific list of entities that qualify as government programs at this time, as we believe that the parameters established in § 156.1250(a) are sufficiently precise.

We are removing § 156.1250(b), the information collection provision, as we believe it will unduly burden Indian tribes, Ryan White HIV/AIDS programs, and government programs to provide such notification to HHS. Although HRSA collects information regarding premium assistance from its Ryan White HIV AIDS programs and grantees, Indian tribes and other Federal, State, and Local government programs may not currently collect or maintain this information. Further, we believe that payment information from these entities would be unlikely to inform the impacts on the risk pool that may result from expanding the requirement at § 156.1250 to third party payments made by non-profit organizations. The latter may make payments for a different population with different health care needs and conditions. We defer the question of acceptance of third-party payments made by non-profit organizations to future rulemaking. We refer stakeholders to our February 7, 2014, FAQ, which clarified that the concerns addressed in our November 4, 2013 FAQ[67] do not apply to payments from private, not-for-profit foundations if the payments are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status. In this situation, the FAQ stated that HHS would expect that the premium and any cost-sharing payments cover the entire policy year.

Comment: Some commenters raised concerns that it would be confusing to create a requirement for issuers or their downstream entities such as PBMs to accept cost sharing from third party payers because there is currently no industry infrastructure in place to facilitate third-party payments, including the lack of the following: Secondary payer guidelines; enrollment file sharing requirements; specific guidelines for accumulators; a coordination of benefits entity to collect and share data with issuers; a transaction facilitator; data exchange agreements; the ability of plans to use common identifiers; and an National Council for Prescription Drug Programs transaction process. Other commenters agreed that when an issuer uses an entity, such as a PBM, to provide a benefit such as prescription drugs, that entity is required to accept third party payments of cost-sharing by virtue of being a downstream entity.

[65] Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Feb. 7, 2014), available at *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf.*

[66] Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Nov. 4, 2013), available at *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf.*

[67] Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Nov. 4, 2013), available at *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf.*

Response: We are finalizing our proposal, with an additional clarification that while issuers offering individual market QHPs, including SADPs, generally do not collect cost-sharing payments, their downstream entities, or agents of the issuer, are required to accept third party cost-sharing payments made by the entities listed at § 156.1250(a) on behalf of QHP enrollees if the downstream entities or agent routinely accept cost-sharing payments from enrollees. We are also clarifying in response to comments, that an agent of the QHP issuer with a mail order pharmacy, such as a PBM with a mail order pharmacy, must accept the third party cost-sharing payments directly from the entities listed at § 156.1250(a).

d. Other Notices (§ 156.1256)

We proposed to add a new § 156.1256, which would add a requirement for issuers, in the case of a plan or benefit display error included in § 155.420(d)(4), to notify their enrollees within 30 calendar days after the error has been identified, if directed to do so by the FFE. We believe that enrollees should be made aware of any error that may have impacted their QHP selection and enrollment and any associated monthly or annual costs. Therefore, we proposed a requirement that issuers, if directed to do so by the FFE, must notify their enrollees of such error, as well as the availability of a special enrollment period, under § 155.420(d)(4), for the enrollee to select a different QHP, if desired.

We are finalizing the provisions with two modifications. In response to comments received, we are amending the timeframe within which issuers must notify their affected enrollees of a plan or benefit display error and the availability of a special enrollment period, from 30 calendar days after the error is identified to 30 calendar days after the issuer is notified by the FFE that the error has been fixed. By waiting until after the error has been corrected, issuers will be more likely to have a complete list of affected enrollees to notify. In addition, by waiting until the error has been corrected and the plan information is properly displayed, enrollees will be able to compare their current plan to others in the service area when deciding whether or not to change plans under the special enrollment period. In addition, we are clarifying that this rule will apply to issuers on SBE–FPs.

Comment: We received general support from commenters for finalizing this proposal, so that consumers are informed about plan or benefit information that was incorrect when they selected that plan and may have impacted their plan selection. One commenter requested that the proposal be extended to State-based Exchanges. Other commenters supported this requirement, but requested that it be limited to those plan or benefit display errors for which issuers are responsible or in cases when issuers fail to comply with the FFE's correction procedures.

Response: We agree with commenters that issuers should notify affected enrollees of display errors that may have impacted plan selection and of their opportunity to select a different plan through the FFE. While we agree that all affected enrollees, regardless of location, should be notified of such errors, we leave it to States operating SBEs to determine the method and timeframe for which enrollees in their Exchanges should be notified. However, SBE–FPs will be using the FFE eligibility and enrollment platform, and, as we note in the preamble to § 156.350 in this final rule, it is not possible at this time for the FFEs to accommodate State customization in policy or operations, such as State-specific display elements in plan compare. Accordingly, we are modifying the regulation text to specify that this rule would require issuers offering QHPs through SBE–FPs to comply with FFE directions to provide notice under this section.

The plan and benefit display errors included in this noticing requirement includes information submitted by issuers to the FFE to be displayed for consumers on Plan Compare. Many errors falling into this category thus far have been due to errors in plan information provided by issuers and all errors in this category have a specific impact on the information available to consumers about one or more plans provided by a particular issuer.

Comment: Many commenters requested additional clarification of the parameters of plan or benefit display errors under § 155.420(d)(4), including whether errors in provider directories or drug formularies, such as those newly accessible through the premium estimator tool, are included in this new notification requirement.

Response: Plan or benefit display errors under § 155.420(d)(4) refer to misinformation, including errors related to service areas, covered services, and premiums, displayed incorrectly on the Exchange Web site. For the FFEs, this only includes the Plan Compare section of the application where a consumer may enroll in a plan. If the plan information incorrectly displayed does not have a direct bearing on coverage or benefits, such as plan contact information, those errors generally do not enable an enrollee to qualify for a special enrollment period under § 155.420(d)(4). Only those plan or benefit display errors that qualify an enrollee for a special enrollment period under § 155.420(d)(4) would trigger this new noticing requirement.

Errors to provider networks or drug formularies, whether incorrectly displayed on the issuer's Web site or accessible through the premium estimator tool on HealthCare.gov, generally do not qualify an enrollee for a special enrollment period. Therefore, issuers are not required to notify affected enrollees in the manner and timeframe outlined in this provision, although notifying enrollees of important changes is encouraged. HHS notes the importance of issuers providing accurate and complete plan information, including provider network and drug formulary information, so that consumers may make informed choices. QHP issuers are reminded that § 156.225(b) prohibits them from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs. Issuers may also be subject to Federal civil rights laws that prohibit discriminatory marketing practices and benefit designs, such as section 1557 of the Affordable Care Act.

Comment: Some commenters requested that that HHS provide model notices for issuers to send to enrollees in the event of a plan or benefit display error. Other requested that issuers retain the flexibility to draft notices to consumers the best way that they see fit.

Response: HHS recognizes that notifying their enrollees of a plan or benefit display error is already included in the business practices of many issuers offering QHPs through the Exchanges and, therefore, issuers have an established method of communicating such errors to their enrollees. HHS also recognizes the need to communicate accurate and standard information about the availability of a special enrollment period to consumers. Therefore, HHS will provide issuers with suggested special enrollment period language that they could use in their existing consumer notices to satisfy the requirement that they notify enrollees of their eligibility for a special enrollment period.

Comment: Several issuers requested that we amend the amount of time issuers have to notify affected enrollees, either by extending it from 30 to 60 calendar days or by starting the 30 calendar days from the date that the

plan or benefit display error has been fixed, while other commenters wanted to ensure that enrollees are notified of an error in a timely manner.

Response: We believe that 30 calendar days is sufficient time for issuers to notify their enrollees affected by a plan or benefit display error and is soon enough to minimize sustained harm to affected enrollees. However, as discussed above, we agree that the 30 calendar days should begin on the date that the issuer is notified that the error has been fixed, and we are amending this provision accordingly.

Comment: One commenter stated that State regulators, including SBEs and departments of insurance, should be responsible for the identification of plan and benefit display errors.

Response: We agree that, States should play a role in identifying plan or benefit display errors, and we encourage State regulators to notify the applicable Exchange of the error. Nothing in this rule prohibits a State from taking that role. We also note that issuers offering QHPs through an FFE must obtain State authorization to change QHP data after certification.

H. Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

1. Definitions (§ 158.103)

In the proposed rule, we proposed to revise the regulatory definitions of large employer and small employer in § 158.103 to cross-reference the definitions of those terms in § 144.103, in order to ensure consistency in those definitions between the MLR regulation and the market reform requirements, and to reflect the recent amendments made by the Protecting Affordable Coverage for Employees Act (Pub. L. 114–60).

Comment: We received two comments supporting this proposal. One commenter suggested that the amendment not apply until the 2016 and later MLR reporting years.

Response: We appreciate the comments regarding the definitions of large employer and small employer. We also agree that although the Protecting Affordable Coverage for Employees Act was passed in and effective as of October 2015, policies that were in effect in 2015 were issued using the group definitions that existed prior to this Act. Therefore, we are finalizing the proposed definitional changes effective with the 2016 MLR reporting year.

2. Reporting of Incurred Claims (§§ 158.103 and 158.140(a))

The MLR December 1, 2010 interim final rule (75 FR 74864) and the May 16, 2012 technical corrections to that rule (77 FR 28788) direct issuers to report incurred claims with a 3-month run-out period, and define unpaid claim reserves to mean reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year. In the proposed rule, we proposed to amend the definition of unpaid claims reserves in § 158.103 and the requirements for reporting incurred claims in § 158.140(a) to utilize a 6-month, rather than a 3-month run-out period, beginning with the 2015 reporting year. The proposed amendment was intended to improve the accuracy of incurred claims amounts in MLR calculation as well as in the risk corridors calculation under a related proposed amendment to § 153.530.

Comment: We received many comments, split equally between supporting the change and opposing it. Some commenters that opposed our proposal requested that any extension in the run-out period include an extension to the filing deadline. Other commenters were principally concerned that the MLR rebate deadline would also be extended, which they believed would harm consumers. One commenter also noted that a longer run-out period could negatively affect States' timely review of issuers' rate filings. Additionally, many opponents noted that the NAIC had considered a 6-month run-out period in 2010 and determined that it would not result in a materially more accurate MLR. The commenters stated that any increase in accuracy would therefore be outweighed by the administrative burden required to update issuer processes. Further, some of these commenters noted that since two of the three premium stabilization programs are temporary and will expire in the near future, HHS could, at that time, revert back to the June 1 MLR filing deadline, rather than maintain the current July 31 deadline that was adopted to accommodate the premium stabilization programs. Commenters point out that this would allow consumers to receive rebates sooner. Supporters of the 6-month run-out period agreed that a longer run-out period would improve the accuracy of MLRs and rebate amounts by utilizing actual rather than estimated claims amounts.

Response: We appreciate the comments supporting our proposal, but also acknowledge the practical considerations raised by the commenters that opposed our proposal. We agree with those commenters that suggested that it may be more beneficial for all stakeholders if we do not modify the run-out period at this time, but instead explore ways to restore the earlier MLR deadlines after two of the three premium stabilization programs expire. Consequently, we are not finalizing the proposed amendments to §§ 158.103 and 158.140(a) regarding unpaid claims reserves and incurred claims, and are retaining the existing 3-month run-out period.

3. Reporting of Fraud Prevention Expenditures

In the proposed rule, we invited comment on whether we should modify the treatment of a health insurance issuer's investments in fraud prevention activities for MLR reporting purposes, noting that we were considering amending the MLR regulation to permit the counting of a health insurance issuer's investments in fraud prevention activities among those expenses attributable to incurred claims. We asked for comments on this approach, including whether safeguards against potential abuse should be included (such as an upper limit on this allowance); whether we should collect fraud prevention activity expense data as an informational item on the MLR Annual Reporting Form before amending the regulation; as well as on potential alternative treatment of these expenses for MLR reporting or rebate calculation purposes. We also asked for any specific, actual data with respect to the additional incentives that would result for health plan investments of this sort.

Comment: We received numerous comments, with the majority opposing any deviation from the current treatment of fraud prevention in MLR. Opponents stated that our proposal to modify treatment of fraud prevention expenses in MLR directly contradicts the NAIC's previous recommendation that such expenses should not be allowed. These commenters noted that the NAIC had conducted extensive debate and analysis of this issue with input from all stakeholders, and had concluded that allowing any additional fraud-related costs in the MLR calculation would be inappropriate. These commenters further stressed that the current rule is working as intended and that there is no evidence that a change is necessary, that fraud prevention is principally a cost-containment expense that should be part of the cost of doing business, and that any benefit to consumers is indirect, or difficult or impossible to isolate. Several commenters requested that we not proceed without additional data, or that we limit any allowance to

0.5 percent of earned premium. Many commenters requested that HHS not finalize the proposal until the NAIC's recently reconvened MLR Quality Improvement Activities subgroup determines whether to support a change in the treatment of fraud prevention expenses. In contrast, other commenters fully supported the proposal, expressing a view that allowing fraud prevention expenses in the MLR calculation would provide issuers an incentive to invest in preventing fraud, waste and abuse. Some of these commenters did not believe that we should impose any caps, while one commenter suggested a cap of 0.3 percent of earned premium. Many of these commenters additionally did not believe that data collection prior to finalizing the proposal would be useful, arguing that issuers have been underinvesting in fraud prevention. Some supporters stated that fraud prevention has a patient safety component, while others focused on the monetary savings for issuers. Some commenters further suggested that issuers would use the money saved through fraud prevention to lower premiums or cost sharing, or on medical services.

Response: We note that no stakeholder has provided specific data to support the notion that allowing fraud prevention expenses in the MLR calculation would have a positive impact. We agree with the commenters who stated that fraud prevention is principally a cost-containment activity, which generally is not permitted in the MLR calculation. In addition, we appreciate the NAIC's indication in its comment letter that its views regarding inclusion of fraud prevention as an adjustment to incurred claims have not changed since its 2010 recommendation. We also agree that, given the possibility that the treatment of fraud prevention may be addressed during the NAIC's review of quality improvement activities that is currently under way, it would be premature for HHS to modify the MLR regulation at this time. Therefore, we are not adopting any changes to the treatment of fraud prevention activities for MLR purposes.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. This final rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden, summarized in Table 11. In the December 2, 2015 (80 FR 75487) proposed rule, we requested public comment on each of the following collection of information requirements. The comments and our responses to them are discussed below.

A. ICRs Regarding Student Health Insurance Coverage (§ 147.145)

The final rule requires issuers of student health insurance coverage to specify the AV of the coverage and the metal level (or next lowest metal level) the coverage would otherwise satisfy. This information must be included in any plan materials summarizing the terms of coverage. We estimate that there are 49 student health insurance issuers nationwide that will each need to provide an average of 25,612 notifications annually.[68] We estimate that each student health insurance issuer will require an average of one hour for clerical staff (at a labor cost of $33.18 per hour) to insert the AV and metal level information into plan materials for all plans offered by the issuer, resulting in a total annual burden of 1 hour and an associated cost of $33.18 per issuer. There is no additional burden to determine these values as student health insurance issuers are currently required to calculate a plan's AV using the AV Calculator. For all 49 issuers currently providing student health insurance coverage, the total combined hour burden is estimated to be 49 hours with a total combined cost of $1,625.82 annually. This information will be included in existing plan materials; therefore, we do not estimate any additional distribution costs.

The final rule discontinues the outdated requirement that student health insurance issuers provide notice informing students that the coverage does not meet the annual limits requirements under section 2711 of the PHS Act. This regulatory provision, by its own terms, no longer applies, as student health insurance coverage is subject to the prohibition on annual dollar limits for policy years beginning or after January 1, 2014. Issuers will experience a reduction in burden related to the discontinued notices, which was previously estimated to be 1,071 hours, with an equivalent labor and mailing cost of $43,757.14 for all student health insurance issuer (under OMB Control No. 0938–1157).

[68] Estimate based on data from Medical Loss Ratio submissions for 2014 reporting year.

B. ICRs Regarding Submission of Risk Corridors Data (§ 153.530)

We finalized our amendment to the risk corridors program requirements at § 153.530 to require issuers to true-up claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year to reflect the actual claims payments made through March 31 of the year following the benefit year. This policy requires issuers to submit data indicating the difference between their incurred liability estimated as of March 31 following the preceding benefit year and March 31 following the current benefit year. While we believe that issuers will be recording these amounts as part of their normal business practices, we estimate that it will take approximately 1 hour for each issuer at $54.44 per hour (according to the wage estimates provided in the MLR notice CMS–10418–OCN 0938–1164) to record these amounts. Therefore, we estimate the overall cost burden of implementing this policy will be $54.44 per issuer, for approximately 320 applicable risk corridors program issuers, for a total cost burden of $17,421.

C. ICRs Regarding Submission of Rate Filing Justification (§ 154.215)

This final rule amends § 154.215 to require health insurance issuers to submit a Unified Rate Review Template (URRT) for all single risk pool coverage regardless of whether there is a plan within a product that experiences a rate increase. The existing information collection requirement is approved under OMB Control Number 0938–1141. This includes the URRT and instructions for rate filing documentation that issuers currently use to submit rate information to HHS for rate increases of any size for single risk pool coverage. We believe most issuers already report this information. However, we estimate the number of URRT submissions may increase by 1 percent due to this requirement. We released information regarding revisions to the information collection template and instructions in accordance with the Paperwork Reduction Act of 1995, in CMS–10379, for a 60-day comment period.[69]

D. ICRs Regarding Election To Operate an Exchange After 2014 (§ 155.106)

This final rule amends the dates for application submission and approval for States seeking to operate an SBE, and have an approved or conditionally

[69] 81 FR 8498 (February 19, 2016). Available at, *https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-03474.pdf.*

approved Exchange Blueprint application and operational readiness assessment. We are not modifying the documents that States already must submit as part of the required Exchange Blueprint application. Therefore, we do not anticipate any additional impact to the administrative burden associated with the regulatory changes to § 155.106. HHS is utilizing the existing PRA package approved under OMB Control Number 0938–1172 for the Exchange Blueprint application.

E. ICRs Regarding Standards for Certified Application Counselors (§ 155.225(b)(1)(iii))

Section 155.225(b)(1)(ii) requires certified application counselor designated organizations to maintain a registration process and method to track the performance of certified application counselors. This final rule adds a new § 155.225(b)(1)(iii) requiring certified application counselor designated organizations to provide the Exchange with information and data regarding the number and performance of the organization's certified application counselors, and the consumer assistance they provide. Although the requirement at § 155.225(b)(1)(ii) does not specify the type of performance information that must be tracked, or require that the information be provided to the Exchange, we expect that certified application counselor designated organizations already have a tracking process in place to collect performance information from individual certified application counselors, and that individual certified application counselors are already recording and submitting this required information to their organization. Therefore, we expect this final rule to have minimal impact on individual certified application counselors and on certified application counselor designated organizations.

Section 155.225(b)(1)(iii) would add a new burden of compiling the performance information and submitting it to the Exchanges. In States with FFEs, HHS anticipates that, beginning for the third quarter of calendar year 2017, it will collect three performance data points each quarter from certified application counselor designated organizations: The number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP. We anticipate that this data will be reported to FFEs electronically, through HIOS or another electronic submission vehicle. For the purpose of estimating costs and burdens, we assume that SBEs will collect the same information with the same frequency, although our rule gives Exchanges the flexibility to determine which data to collect and the form and manner of the collection. We estimate that certified application counselor designated organizations will have a mid-level health policy analyst prepare the reports and a senior manager will review each quarterly report. HHS expects that a mid-level health policy analyst (at an hourly wage rate of $40.64) will spend 2 hours each quarter to provide the required quarterly submissions and a senior manager (at an hourly wage rate of $91.31) will spend ⅜ hour to review the submissions. Therefore, we estimate each quarterly report will require 2.375 hours and a cost burden of $115.52 per quarter per organization, or 9.50 hours with a cost (four quarterly reports) of $462.08 annually per certified application counselor designated organization. Nationwide, we estimate there are 5,000 certified application counselor designated organizations, resulting in an annual cost burden of $2,310,400 and 47,500 hours for certified application counselor designated organizations.

Under § 155.225(b)(1)(iii), if an Exchange requests these certified application counselor reports, the Exchange would also need to review the reports. We assume that all Exchanges will require quarterly reports and will utilize in-house staff to review them. We assume that an employee earning a wage that is equivalent to a mid-level GS–11 employee would review quarterly report submissions from certified application counselor designated organizations.[70] We estimate that a mid-level employee (at an hourly wage rate of $43.13) will spend 10 minutes reviewing each quarterly report for a cost burden of approximately $7.19 per quarterly report per certified application counselor designated organization. For all SBEs, we estimate that there are 1,500 certified application counselor designated organizations resulting in a cost burden of 1,000 hours and approximately $43,130 annually. Costs to the FFEs are estimated separately in the Regulatory Impact Analysis section of this final rule.

[70] Federal wage rates are available at *https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/GS_h.pdf.*

F. ICRs Regarding Network Adequacy Standards (§ 156.230(d) and (e))

Section 156.230(d) requires that QHP issuers make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. This is a third-party disclosure requirement. The notification requirement under § 156.230(d)(1) is a common practice in the current market as several States, Medicare Advantage, Medicaid Managed Care, and the NAIC Network Adequacy Model Act have standards regarding enrollee notification of a provider leaving a network. As discussed in the preamble, under State laws, many QHP issuers will already be under this obligation, and therefore, our notification requirements will apply in a more limited fashion. Additionally, we incorporated SADPs into our calculations, but we recognize given the notification requirements that SADPs may rarely need to send a notification.

We estimate that a total of 475 issuers participate in the FFE and would be required to comply with the standard. We estimated that 5 percent of providers discontinue contracts per year, and that an issuer in the FFE covers 7,500 National Provider Identifiers, which means that we estimate an issuer would have 375 provider discontinuations in a year. In response to comment to the proposed rule, we are clarifying that our assumption is that the database manager will receive notification from the issuer's contracting team that a provider contract is being discontinued. From that notification, the database manager would aggregate the claims data associated with the provider to develop the list of effected enrollees with associated enrollee information for the notice. This list of affected enrollees and associated enrollee information would be sent to an administrative assistant to aggregate into a notification template to be sent to the enrollee. Assuming 375 notifications per year, we believe that this task would be a routine process for the administrative assistant to undertake that would need little to no oversight to produce. As the issuer has the discretion to define regular basis and that the number of notifications are likely to widely varying between network and type of provider, we did not estimate based on the number of

individual notifications, but rather the number of provider discontinuations. For each provider discontinuation, we estimate that it will take a database administrator 30 minutes for data analysis to produce the list of affected enrollees, at $55.37 an hour, and an administrative assistant 30 minutes to develop the notification and send the notification to the affected enrollees, at $29.93 an hour. In response to comment, we are also clarifying these hourly rates include 35 percent adjustment for fringe benefits and overhead costs. The total costs per issuer would be $15,993.75. The total annual costs estimate would be $7,597,031. Because we are already collecting information regarding network classifications as part of the existing QHP certification process, we do not believe that the network classifications described in the preamble will result in additional information collection requirements for issuers.

In § 156.230(e), we require QHP issuers to provide a notice to enrollees of the possibility of out-of-network charges from an ancillary out-of-network provider in an in-network setting prior to the benefit being provided, to avoid counting the out-of-network costs against the annual limitation on cost sharing. This provision applies to all QHPs, which includes 575 issuers, and would start in 2018. We estimate it would take an issuer's mid-level health policy analyst (at an hourly wage rate of $54.87) approximately 6 minutes to create a notification and send the information. In response comments, we are clarifying the hourly rates include 35 percent adjustment for fringe benefits and overhead costs. We estimate that approximately two notices would be sent for every 100 enrollees. Assuming approximately 24 million enrollees in QHPs for 2018,[71] we estimate QHPs would send approximately 320,000 total notices, for a total 21,334.40 hours, at a total cost of $1,170,619.

G. ICR Regarding Monthly SHOP Enrollment Reconciliation Files Submitted by Issuers (156.285(c)(5))

We are finalizing amendments to § 156.285(c)(5) to specify that issuers in a Federally-facilitated SHOP would send monthly enrollment reconciliation files to the SHOP according to a process, timeline and file format established by the FF–SHOP. We anticipate that this would require FF–SHOP issuers to submit a standard file with specific data elements and submit their files in a process set out by the SHOP, at least monthly. Issuers of QHPs available through the SHOP are already required under the current version of § 156.285(c)(5) to reconcile enrollment files with the SHOP at least monthly. Therefore, we expect this policy to have minimal impact on SHOP issuers.

H. ICR Regarding Patient Safety Standards (§ 156. 1110)

In § 156.1110(a)(2)(i), for plan years beginning on or after January 1, 2017, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital uses a patient safety evaluation system and implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient. In § 156.1100(a)(2)(ii), we also establish reasonable exceptions to these new QHP issuer patient safety requirements (rather than requiring reporting of such information to a Patient Safety Organization). The burden estimate associated with the information collection, recordkeeping, and disclosure requirements to demonstrate compliance with these standards includes the time and effort required for QHP issuers to maintain and submit to the applicable Exchanges documentation that would include hospital agreements to partner with, or other information demonstrating a partnership with, a Patient Safety Organization, a Hospital Engagement Network, or a Quality Improvement Organization that demonstrate that each of its contracted hospitals with greater than 50 beds meets the patient safety standards required in § 156.1110(a)(2) for plan years beginning on or after January 1, 2017. QHP issuers may not already be collecting such network provider information; therefore, we estimate the cost and burden to collect this administrative information as follows: For a total of 575 QHP issuers, offering 15 plans as potential QHPs, we estimated each issuer would require one senior manager an average of 3 hours to collect and maintain the hospital agreements or other information necessary to demonstrate compliance as required in § 156.1110(a)(2) for their QHPs offered on Exchanges for plan years beginning on or after January 1, 2017. For a senior manager (at an hourly wage rate of $91.31), we estimated the total annual cost for a QHP issuer to be $273.93. Therefore, we estimated a total annual burden of 1,725 hours, resulting in an annual cost of $157,510.

I. ICRs Regarding Other Notices (§ 156.1256)

We are adding a new section at § 156.1256 to require that, in the event of a plan or benefit display error, QHP issuers notify their enrollees within 30 calendar days after the issuer is informed by the FFE that the error has been fixed, if directed to do so by the FFE, both of the plan or benefit display error and of the opportunity to enroll in a new QHP under a special enrollment period at § 155.420(d)(4), if directed to do so by the FFE. This provision would apply to all QHPs in the FFEs, as well as all QHPs in the SBE–FPs, which includes 475 issuers. We anticipate that issuers will need to notify multiple enrollees of the same display error, and therefore estimate that one form notice would cover approximately 100 of the enrollees receiving such a notice. For each group of 100 form notices, we estimate that it would take approximately 30 minutes for an issuer's mid-level health policy analyst (at an hourly wage rate of $54.87) to amend, add SEP language provided by the FFE, and send the information. We estimate that approximately 4 percent of enrollees would receive such a notice. Assuming approximately 19 million FFE and SBE–FP enrollees in 2017,[72] we estimate QHPs in the FFEs and SBE–FPs would send approximately 760,000 total notices (4 percent of the estimated 19 million FFE and SBE–FP enrollees), for a total hours of 3,800, with a total cost of $208,506.

Although this final rule requires issuers to send notices for the specified situation, sending these notices is already part of normal issuer business practices and issuers are already working with the FFE to include language in their notices about special enrollment periods, as applicable and appropriate. Therefore, there will be no additional information required by issuers and no new administrative burden as a result of this final rule. In accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe the burden associated with this requirement would be exempt as it associated with a usual and customary business practice.

[71] We used the most recent CBO estimates for enrollment from March 2015 available at *https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.*

[72] We applied the current FFE to total Exchange enrollment ratio to the most recent CBO estimates for total Exchange enrollment from March 2015 available at *https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.*

TABLE 11—ANNUAL REPORTING, RECORDKEEPING AND DISCLOSURE BURDEN

Regulation Section	OMB Control No.	Number of respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting ($)	Total labor cost of reporting ($)	Total cost ($)
§ 147.145—AV	0938–1157	49	25,612	1	49	33.18	1,625.82	1,625.82
§ 153.530	0938–1164	320	1	1	320	54.44	17,421	17,421
§ 155.225 (b)(1)(iii)—certified application counselor (CAC) organizations	0938–1172	5,000	4	2.375	47,500	48.64	2,310,400	2,310,400
§ 155.225 (b)(1)(iii)—SBE	0938–1172	1,500	4	0.167	1,000	43.13	43,130	43,130
§ 156.230(d)	0938–NEW	475	375	1	375	85.3	7,597,031	7,597,031
§ 156.230(e)	0938–NEW	575	320,000	0.1	32,000	54.87	1,170,619	1,170,619
§ 156.1110	0938–1249	575	8,625	0.2	1,725	91.31	157,510	157,510
§ 156.1256	0938–NEW	475	760,000	0.5	3,800	54.87	208,506	208,506
Total		5,575			86,769		11,506,243	11,506,243

Note: There are no capital/maintenance costs associated with the information collection requirements contained in this rule; therefore, we have removed the associated column from Table 11.

We have submitted an information collection request to OMB for review and approval of the ICRs contained in this final rule. The requirements are not effective until approved by OMB and assigned a valid OMB control number.

V. Regulatory Impact Analysis

A. Statement of Need

This rule sets forth standards related to the premium stabilization programs (risk adjustment, reinsurance, and risk corridors) for the 2017 benefit year, as well as certain modifications to these programs that will protect issuers from the potential effects of adverse selection and protect consumers from increases in premiums due to issuer uncertainty. The Premium Stabilization Rule and previous Payment Notices provided detail on the implementation of these programs, including the specific parameters for the 2014, 2015, and 2016 benefit years applicable to these programs. This rule provides additional standards related to essential health benefits, consumer assistance tools and programs of an Exchange, Navigators, non-Navigator assistance personnel, agents and brokers registered with the Federally-facilitated Exchange, certified application counselors, cost-sharing parameters and cost-sharing reduction notices, essential community providers, qualified health plans, network adequacy, stand-alone dental plans, acceptance of third-party payments by QHP issuers, patient safety standards for issuers of qualified health plans participating in Exchanges, the rate review program, the medical loss ratio program, the Small Business Health Options Program, and FFE user fees.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year).

OMB has determined that this final rule is ''economically significant'' within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. Accordingly, we have prepared an RIA that presents the costs and benefits of this rule.

Although it is difficult to assess the effects of these provisions in isolation, the overarching goal of the premium stabilization, market standards, and Exchange-related provisions and policies in the Affordable Care Act is to make affordable health insurance available to individuals who do not have access to affordable employer-sponsored coverage. The provisions within this rule are integral to the goal of expanding coverage. For example, the premium stabilization programs help prevent risk selection and decrease the risk of financial loss that health insurance issuers might otherwise expect in 2017 and Exchange financial assistance assists low- and moderate-income consumers and American Indians/Alaska Natives in purchasing health insurance. The combined impacts of these provisions affect the private sector, issuers, and consumers, through increased access to health care services including preventive services, decreased uncompensated care, lower premiums, establishment of the next phase of patient safety standards, and increased plan transparency. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these provisions are expected to increase access to affordable health coverage.

HHS anticipates that the provisions of this rule will help further the Department's goal of ensuring that all consumers have access to quality and affordable health care and are able to make informed choices, that Exchanges operate smoothly, that premium stabilization programs work as intended, that SHOPs are provided flexibility, and that employers and consumers are protected from fraudulent and criminal activities. Affected entities such as QHP issuers would incur costs to comply with the established provisions, including administrative costs related to notices, new patient safety requirements, and training and recertification requirements. In accordance with Executive Order 12866, HHS believes that the benefits of this regulatory action justify the costs.

Comment: A commenter criticized the regulatory analysis for lacking an adequate economic analysis. The

commenter criticized the credibility of the sources of the estimates and assumptions used. Additionally, the commenter noted that in Table 12 the magnitude of cost estimates is not labeled, and the costs associated with the user fee to be assessed on issuers in State-based Exchanges using the Federal platform were not included in the analysis.

Response: We previously estimated the annualized impact on issuers, contributing entities, and States of transfers and other programs in the 2014, 2015 and 2016 Payment Notice rules. Therefore, to avoid double-counting, Table 12 contains only incremental changes incurred as a result of provisions in this rule. The results of HHS's internal analyses were used to assess the impact of the policies of this rule. For this analysis, we continue to believe that the best available estimates of the impact of the Affordable Care Act on the Federal budget, enrollment in health insurance programs, and revenue collection are by the Congressional Budget Office. The CBO's most recent updates are available at *https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.* We have clarified the units for the cost estimates in Table 12. We also note that the estimate of user fees to be assessed on issuers in State-based Exchanges using the Federal platform has been incorporated in the annual monetized costs described in Table 12.

C. Impact Estimates of the Payment Notice Provisions and Accounting Table

In accordance with OMB Circular A–4, Table 12 depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this regulatory action.

This final rule implements standards for programs that will have numerous effects, including providing consumers with affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in an Exchange. We are unable to quantify certain benefits of this final rule—such as improved health outcomes and longevity due to continuous quality improvement, improved patient safety and increased insurance enrollment—and certain costs—such as the cost of providing additional medical services to newly-enrolled individuals. The effects in Table 12 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this final rule for health insurance issuers. The annualized monetized costs described in Table 12 reflect direct administrative costs to health insurance issuers as a result of the finalized provisions, and include administrative costs related to student health insurance coverage, rate filing justification, notices, new patient safety requirements, and training and recertification requirements that are estimated in the Collection of Information section of this final rule. The annual monetized transfers described in Table 12 include costs associated with FFE user fees and the risk adjustment user fee paid to HHS by issuers. We estimate that that the total cost for HHS to operate the risk adjustment program on behalf of States for 2017 will be approximately $24 million and that the risk adjustment user fee would be $1.56 per enrollee per year from risk adjustment issuers, which is less than the anticipated $50 million in benefit year 2016 for which we established a $1.75 per-enrollee-per-year risk adjustment user fee amount. We reassessed our contract costs for 2017 and were able to base 2017 risk adjustment eligible plan enrollment projections on actual 2014 risk adjustment enrollment. We revised our user fee rate from the proposed amount to reflect these considerations. Also, the increase in FFE user fee collections is the result of expected growth in enrollment in the FFEs rather than an increase in the user fee rate, which at 3.5 percent remains the same from 2016 to 2017. Beginning in 2017, we are also charging a user fee for State-based Exchanges using the Federal platform for eligibility and enrollment services. This user fee rate would be set at 1.5 percent for benefit year 2017.

TABLE 12—ACCOUNTING TABLE

Benefits:

Qualitative:

- Increased enrollment in the individual market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures.
- Continuous quality improvement among QHP issuers to reduce patient harm and improve health outcomes at lower costs.
- More informed Exchange QHP certification decisions.
- Increased coverage options for small businesses and employees with minimal adverse selection.

Costs	Estimate	Year dollar	Discount rate percent	Period covered
Annualized Monetized ($millions/year)	$11.67	2016	7	2016–2020
	$11.67	2016	3	2016–2020

Quantitative:

- Costs reflect administrative costs incurred by issuers and States to comply with provisions in this final rule.

Transfers	Estimate	Year dollar	Discount rate percent	Period covered
Annualized Monetized ($millions/year)	$25.89	2016	7	2016–2020
	$25.86	2016	3	2016–2020

- Transfers reflect a decrease in annual cost of risk adjustment user fees (the total risk adjustment user fee amount for 2016 was $50 million and $24 million for 2017), which are transfers from health insurance issuers to the Federal government. Transfers also reflect an increase of $30 million in 2017 and $65million in future years, in the amount of user fees collected from State-based Exchanges that use the Federal platform for eligibility and enrollment which are transfers from issuers to the Federal government.
- Unquantified: Lower premium rates in the individual market due to the improved risk profile of the insured, competition, and pooling.

This RIA expands upon the impact analyses of previous rules and utilizes the Congressional Budget Office's (CBO) analysis of the Affordable Care Act's impact on Federal spending, revenue collection, and insurance enrollment. The temporary risk corridors program and the transitional reinsurance program end after the 2016 benefit year. Therefore, the costs associated with those programs are not included in Tables 12 or 13 for fiscal years 2019–2020. Table 13 summarizes the effects of the risk adjustment program on the Federal budget from fiscal years 2016 through 2020, with the additional, societal effects of this rule discussed in this RIA. We do not expect the provisions of this final rule to significantly alter CBO's estimates of the budget impact of the premium stabilization programs that are described in Table 13. We note that transfers associated with the risk adjustment and reinsurance programs were previously estimated in the Premium Stabilization Rule; therefore, to avoid double-counting, we do not include them in the accounting statement for this rule (Table 12).

In addition to utilizing CBO projections, HHS conducted an internal analysis of the effects of its regulations on enrollment and premiums. Based on these internal analyses, we anticipate that the quantitative effects of the provisions in this rule are consistent with our previous estimates in the 2016 Payment Notice for the impacts associated with the advance payments of cost-sharing reductions and premium tax credits, the premium stabilization programs, and FFE user fee requirements.

TABLE 13—ESTIMATED FEDERAL GOVERNMENT OUTLAYS AND RECEIPTS FOR THE RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS PROGRAMS FROM FISCAL YEAR 2016–2020, IN BILLIONS OF DOLLARS

Year	2016	2017	2018	2019	2020	2016–2020
Risk Adjustment, Reinsurance, and Risk Corridors Program Payments	16.5	19.5	13	15	16	80
Risk Adjustment, Reinsurance, and Risk Corridors Program Collections *	15.5	18.5	13	15	16	78

Note 1: Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time.
Note 2: The CBO score reflects an additional $2 million in collections in FY 2015 that are outlayed in the FY 2016–FY 2020 timeframe. CBO does not expect a shortfall in these programs.
Source: Congressional Budget Office. Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline Table *https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.*

1. Fair Health Insurance Premiums

The final rule permits a rating area to be identified for a small employer that is within the service area of an issuer's network plan, for purposes of rating based on geography where the employer's principal business address is not within that service area. This will ensure that the network plan can be appropriately rated for sale to the group policyholder, benefitting both issuers and employers.

2. Student Health Insurance Coverage

The final rule eliminates the requirement that issuers of student health insurance coverage provide coverage comprised of the specific metal levels, and instead requires that student health insurance coverage provide at least 60 percent AV. The final rule also requires issuers of student health insurance coverage to specify in any plan materials summarizing the terms of coverage the AV of the coverage and the metal level (or next lowest metal level) the coverage would otherwise satisfy. This will provide flexibility for institutions of higher education to offer student health insurance plans that are more generous than the standard metal levels, while providing students with information that allows them to compare the generosity of student health insurance coverage with other available coverage options. This will affect an estimated 49 issuers nationwide that offer student health insurance coverage and approximately 1.4 million students and dependents enrolled in such plans.[73]

3. Risk Adjustment

The risk adjustment program is a permanent program created by the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. We established standards for the administration of the risk adjustment program, in subparts D and G of part 45 of the CFR.

A State approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf. As described in the 2014, 2015, and 2016 Payment Notices, if HHS operates risk adjustment on behalf of a State, it will fund its risk adjustment program operations by assessing a risk adjustment user fee on issuers of risk adjustment covered plans. For the 2017 benefit year, we estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2017 will be approximately $24 million, and that the risk adjustment user fee would be $1.56 per enrollee per year. This user fee reflects our reassessment of both contract costs to support the risk adjustment program in 2017 and the expected member month enrollment in risk adjustment covered QHPs.

4. Risk Corridors

The Federally operated temporary risk corridors program ends in benefit year 2016 as required by statute. Because risk corridors charges are collected in the year following the applicable benefit year, and risk corridors payments lag receipt of collections by one quarter, we estimate that risk corridors transfers will continue through fiscal year 2018. In this rule, we establish that for the 2015 and 2016 benefit years, the issuer must true up claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year to reflect the actual claims payments made through March 31 of the year following the benefit year. This amendment provides for a more accurate risk corridors calculation by substituting actual experience in place of estimates. Some issuers overestimate their claims and liabilities, while others underestimate them. Based on the 2014 MLR and risk corridors data, we estimate that this amendment will result in a combined total reduction in risk corridors payments or increase in risk corridors charges for some issuers; and a combined total increase in risk corridors payments or decrease in risk corridors charges for other issuers. HHS

[73] Source: Data from Medical Loss Ratio submissions for 2014 reporting year.

continues to implement the risk corridors program in a budget neutral manner such that payments are made from collections that are received. If collections are insufficient to fund payment obligations, HHS will apply a pro rata reduction to risk corridors payments to issuers for the benefit year. Because of uncertainty in the amount of collections that will be received for payment for the 2015 benefit year, we are unable to estimate the magnitude of the net impact of the modification in the final rule, but believe that it will reduce the overall amount of risk corridors transfers for the 2015 benefit year.

5. Rate Review

In § 154.215, we amend the criteria for submission of the Unified Rate Review Template for single risk pool coverage to HHS. We expect URRT submissions may increase by 1 percent. We have revised the information collection currently approved under OMB Control Number 0938–1141 to clarify instructions related to completing the template for single risk pool coverage.

6. Additional Required Benefits

In § 155.170, we amended the requirement for coverage of benefits in addition to the essential health benefits. Specifically, we are rewording § 155.170(a)(2) to make clear that a benefit required by the State through action taking place on or before December 31, 2011 is considered an EHB and one required by the State through action taking place after December 31, 2011 is considered in addition to EHB. As we see this as a clarification, we do not anticipate an additional burden on States or issuers. At § 155.170(a)(3), we currently require the Exchange to identify which additional State-required benefits, if any, are in excess of EHB. We amended paragraph (a)(3) to designate the State, rather than the Exchange, as the entity that identifies which State-required benefits are not EHB. Because Exchanges have been relying upon State departments of insurance in determining what constitutes an essential health benefit, we do not anticipate any additional burden to States because of this modification, but simply a shift in burden from one State agency to another.

7. Standards for Navigators and certain Non-Navigator Assistance Personnel

This final rule amends some of the standards for consumer assistance functions under § 155.205(d) and (e), as well as for the activities of Navigators under § 155.210, and non-Navigator assistance personnel subject to § 155.215. The changes include ensuring consumers have access to skilled assistance with Exchange-related issues beyond applying for and enrolling in coverage. Such post enrollment and other assistance includes assisting consumers with applying for exemptions from the individual shared responsibility payment that are granted through the Exchange, with understanding the process of filing Exchange appeals, and with understanding basic concepts and rights related to health coverage and how to use it. The final rule also requires Navigators to provide targeted assistance to serve underserved or vulnerable populations, as identified by each Exchange. In addition, the final rule specifies that any individual or entity carrying out consumer assistance functions under § 155.205(d) and (e) or § 155.210 must complete training prior to performing any assister duties, including conducting outreach and education activities.

The final rule's amendments to §§ 155.205(d) and 155.215(b)(1)(i) related to completing training for Navigators and non-Navigator assistance personnel apply only to the timing of the training and do not have any impact on the training itself. Therefore, they do not affect the burden or cost for entities already subject to training requirements. Because under existing § 155.215(b)(2), Navigators in FFEs must already be trained on the tax implications of enrollment decisions, the individual responsibility to have health coverage, eligibility appeals, and rights and processes for QHP appeals and grievances, we expect our amendments to § 155.210(b)(2)(v) through (ix) to have minimal impact on FFE training. If any SBEs do not already provide training on these topics, we expect they would incur minimal costs in developing and implementing this training. Our final rule requiring Navigators to provide targeted assistance to underserved or vulnerable populations will have an increased benefit for consumers, especially hard to reach populations. All costs associated with reaching these consumers in FFEs are considered allowable costs that would be covered by the Navigator grants for the FFEs and that may be drawn down as the grantee incurs such costs. Additionally, § 155.210(b)(2)(i) already requires Navigators in all Exchanges to receive training on the needs of underserved and vulnerable populations.

8. Certified Application Counselors

This final rule requires certified application counselor organizations to submit data and information to the Exchanges regarding the number and performance of their certified application counselors and the consumer assistance they provide, upon request, in a form and manner specified by the Exchange. Under § 155.225(b)(1)(iii), if an Exchange requests these certified application counselor reports, the Exchange would also need to review them. We assume that all Exchanges will require quarterly reports and will utilize in-house staff to review them. We assume that an employee earning a wage that is equivalent to a mid-level GS–11 employee would review quarterly report submissions from certified application counselor designated organizations.[74] We estimate that a mid-level employee (at an hourly wage rate of $43.13) will spend 10 minutes reviewing each quarterly report for a cost burden of approximately $7.19 per quarterly report per certified application counselor designated organization. We estimate the costs of this requirement for State Exchanges in the Collection of Information Requirements section of this final rule. For the FFEs, we estimate there are 3,500 certified application counselor designated organizations, resulting in a total annual burden for FFEs of 2,333 hours, at a cost of $100,660.

9. SHOP

The SHOP facilitates the enrollment of eligible employees of eligible small employers into small group health insurance plans. A qualitative analysis of the costs and benefits of establishing a SHOP was included in the RIA published in conjunction with the Exchange Establishment Rule.[75] Section 155.735(d)(2)(iii), added in this rule, requires the FF–SHOPs to send qualified employees a notice notifying them in advance of a child dependent's loss of eligibility for dependent child coverage under their plan because of age. The notice will be sent 90 days in advance of the date when the dependent enrollee would lose eligibility for dependent child coverage. We estimate the FF–SHOPs will spend roughly 35 hours annually, per State, to prepare the notice, for a total cost of $1,775, per State, to design and implement the notices under § 155.735(d)(2)(iii). We estimate that there will be approximately 32 States operating under the FF–SHOPs and all will be subject to this requirement. Therefore, we estimate

[74] Federal wage rates are available at *https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/GS_h.pdf.*

[75] Available at *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf.*

a total annual cost of $58,575 for the FF–SHOPs as a result of this requirement.

10. Standardized Options

In assessing the burden associated with implementing standardized options, as described in § 156.20, we assessed the potential impact on premiums established by QHP issuers in the FFEs. We anticipate that an issuer will price a standardized option based on how similar or different the standardized option is to the issuer's current shelf (plan offerings). Because of the large variation across the country, we expect that how standardized options will be priced will vary by issuer and by State. We do not anticipate that it will significantly affect 2017 plan premiums. We expect that issuers will offer standardized options at a given metal level if the standardized options are similar to their existing plans and can be priced competitively.

The premium impact on issuers' non-standard plan offerings is difficult to estimate. Among the six State Exchanges that standardized plans and required standardized options to be offered by QHP issuers in 2014, two (California and New York) that attempted to conduct premium impact analysis found that introduction of the requirement on issuers to offer standardized options was associated with a negligible or downward impact on premiums. However, these SBEs found it was difficult to isolate the effects of plan standardization on premiums given the many changes that occurred in the insurance market in 2014 (including the uptake in individual market enrollment, the movement to narrow networks, and active purchasing and rate negotiation in California).

Again, we note that there is a great deal of uncertainty in how this policy will affect Exchanges due to several considerations:

- While we standardize cost-sharing on key essential health benefits, there are a wide range of other benefit design parameters that we will not standardize. It is not clear how this differentiation will manifest among plans or affect consumer choice.

- There is also wide geographic variation in health care markets, including with respect to prices, plan designs, and provider networks. As such, we anticipate that the take-up of standardized options and their impacts on consumers will vary in different locations across the country.

11. User Fees

To support the operation of FFEs, we require in § 156.50(c) that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE. In this final rule, for the 2017 benefit year, we finalize a monthly FFE user fee rate equal to 3.5 percent of the monthly premium. For a State-based Exchange using the Federal platform, we finalize a user fee rate equal to 1.5 percent of the monthly premium. For the accounting statement of this rule, we have reduced the incremental increase in the user fee collected for the first year by one-half, after which we estimate $30 million in the amount of user fees collected from State-based Exchanges that use the Federal platform for 2017 and $65 million for years after 2017. For the user fee charges assessed on issuers in the FFE, we have previously received a waiver to OMB Circular No. A–25R, which requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. Similarly, for this year, for the user fee charges assessed on issuers in the FFE and State-based Exchanges using the Federal platform, we have sought an exception to OMB Circular No. A–25R, which requires that the user fee charge be sufficient to recover the full cost to the Federal government of providing the special benefit. This exception ensures that the FFE can support many of the goals of the Affordable Care Act, including improving the health of the population, reducing health care costs, and providing access to health coverage as advanced by § 156.50(d).

12. Actuarial Value

In response to comments, we are clarifying that we take into consideration stakeholder feedback on needed changes. One commenter asked for the basis on which we concluded that the cost sharing changes that might be required by a change to the AV calculator would likely be minor. We note that because of the de minimis range established at § 156.140, many plans do not require significant changes to cost-sharing structure each year beyond those permitted by the statute (such as for changes to the annual limitation on cost sharing). However, where significant changes are required, for example when a plan has reached the permissible de minimis limit and the change in annual limitation on cost sharing does not fully accommodate changed calculations established by an updated AV Calculator, we acknowledge that plans likely engage in significant analysis in order to establish new cost-sharing structures. We do not anticipate that our policy providing us with additional flexibility in updating the AV Calculator will substantially change the number of plans for which new cost-sharing structures must be calculated each year—it is our intent to continue to provide annual updates to the AV Calculator.

13. Network Adequacy

In § 156.230(e), we are finalizing our proposal to require QHPs in the FFEs to count certain out-of-network cost sharing towards the in-network annual limitation on cost sharing for enrollees who receive EHB from an out-of-network *ancillary* provider at an in-network setting, with modifications. The premium impact will vary based on existing State laws. We received no comments on this estimate.

14. Provisions Related to Cost Sharing

The Affordable Care Act provides for the reduction or elimination of cost sharing for certain eligible individuals enrolled in QHPs offered through the Exchanges. This assistance will help many low- and moderate-income individuals and families obtain health insurance—for many people, cost sharing is a barrier to obtaining needed health care.[76]

We set forth in this rule the reductions in the maximum annual limitation on cost sharing for silver plan variations. Consistent with our analysis in previous Payment Notices, we developed three model silver level QHPs and analyzed the impact on their AVs of the reductions described in the Affordable Care Act to the estimated 2017 maximum annual limitation on cost sharing for self only coverage ($7,150). We do not believe these changes will result in a significant economic impact. Therefore, we do not believe the provisions related to cost-sharing reductions in this rule will have an impact on the program established by and described in the 2015 and 2016 Payment Notices.

[76] Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment.* Santa Monica, CA: RAND Corporation, 1984. Available at *http://www.rand.org/pubs/reports/R3055.*

We also finalize the premium adjustment percentage for the 2017 benefit year. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. The annual premium adjustment percentage sets the rate of increase for three parameters detailed in the Affordable Care Act: the annual limitation on cost sharing (defined at § 156.130(a)), the required contribution percentage by individuals for minimum essential coverage the Secretary may use to determine eligibility for hardship exemptions under section 5000A of the Code, and the assessable payments under sections 4980H(a) and 4980H(b). We believe that the 2017 premium adjustment percentage of 13.25256291 percent is well within the parameters used in the modeling of the Affordable Care Act, and we do not expect that these provisions will have a substantial, if any, effect on CBO's March 2016 baseline estimates of the budget impact.

15. Stand-Alone Dental Plans

In § 156.150, we are increasing the annual limitation on cost sharing for stand-alone dental plans being certified by the Exchanges. We believe that the benefit of increasing the annual limit on cost sharing is that issuers would be able to offer consumers SADPs that provide preventive care without any cost sharing, similar to what is generally offered by SADPs in the large group market. We received several comments noting that preventive care without any cost sharing would be easier to achieve with a high annual limitation on cost sharing. We have established that increasing the annual limitation on cost sharing over time will decrease the likelihood of premium increases.

16. Meaningful Difference

In § 156.298, we remove the health savings account eligibility and the individual coverage or enrollment group coverage criteria as options for meeting the meaningful difference standard. As we believe the health savings account eligibility criterion to overlap with cost-sharing criterion (that is, we believe that a plan that meets the meaningful difference standard for health savings account eligibility would also meet the standard under the cost-sharing criterion), we do not believe that removing this criterion will have any impact on issuers. Additionally, our records indicate that no other than self-only coverage plans were reviewed for meaningful difference in 2015 and none are offered for 2016 Open Enrollment, meaning that there will be limited impact on removing these criteria. As such, we estimate that the impact of this change is negligible.

17. Patient Safety Standards

The next phase of patient safety standards requires QHP issuers participating in Exchanges to track hospital participation with PSOs or other evidence-based patient safety initiatives. We believe this new requirement to verify that hospitals use a patient safety evaluation tool and implement a comprehensive person-centered hospital discharge program would encourage continuous quality improvement among QHP issuers by strengthening system-wide efforts to reduce patient harm in a measurable way, improve health outcomes at lower costs, allow for flexibility and innovation in patient safety interventions and practices, and encourage meaningful health care quality improvements. We discuss the administrative costs associated with submitting this information in the Collection of Information section of this final rule.

18. Acceptance of Certain Third Party Payments

On March 19, 2014, we published in the **Federal Register** an interim final rule (IFR) with comment period titled, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums (79 FR 15240). In § 156.1250, we finalize this rule to require individual market QHPs and SADPs to accept premium payments made by certain third parties. This rule describes the circumstances in which individual market QHPs and SADPs must accept payments made by Ryan White HIV/AIDS program; Federal and State government programs that provide premium and cost sharing support for specific individuals; and Indian tribes, tribal organizations, and urban Indian organizations. We do not believe these actions would impose any significant new costs on issuers because we assume that most issuers already accept such payments under our interim final rule.

19. Medical Loss Ratio

This final rule amends the risk corridors program requirements at § 153.530 to require issuers to true-up the claims liabilities and reserves used to determine the 2014 and 2015 allowable costs to reflect the actual claims payments made through March 31, 2016 and March 31, 2017, respectively. We discuss the impact of this proposal on the risk corridors program elsewhere in this RIA. Because risk corridors payments and charges are a component of the MLR and rebate calculation, the impact of this amendment on risk corridors payments and charges may in turn affect MLR rebates to consumers. While, as noted previously, we are unable to estimate the magnitude of the net impact of this modification on risk corridors transfers, and consequently on MLR rebates, we believe that this amendment would increase rebate payments from issuers to consumers.

D. Regulatory Alternatives Considered

In developing the policies contained in this final rule, we considered numerous alternatives to the presented proposals. Below we discuss the key regulatory alternatives that we considered.

Regarding the open enrollment periods for 2017 and beyond, we considered gradually shifting the end of the open enrollment period earlier. However, we believe keeping the open enrollment period the same for benefit years 2017 and 2018 as it was for 2016 and then moving to a December 15 end date simplifies messaging to consumers, while achieving our ultimate goal of shifting the open enrollment period so that it ends prior to the start of the benefit year.

Regarding the 2017 required contribution percentage, which establishes the threshold for spending on minimum essential coverage required for an affordability exemption from the individual shared responsibility requirement, we considered continuing to use the per capita gross domestic product as the measure of income growth. However, a new measure of income growth, per capita personal income, became available for the first time last year as part of the National Health Expenditure's projections, and includes not only participation in production but also transfer payments. We believe that this broader measure of personal income more accurately reflects individual income than GDP per capita.

For SBE–FP model provisions at § 155.200(f), we considered a number of alternatives. We considered not codifying the SBE–FP model, and winding down use of the Federal platform by SBEs. In this alternative, SBEs currently utilizing these services would have had to find a way to perform all required Exchange eligibility and enrollment functions themselves, including the implementation of an Exchange technology platform, or else convert to FFEs. We finalized the

proposal without significant change because we believe that it is technically feasible and will permit a number of SBEs to access the Federal government's greater economies of scale. We also considered a more customized option, under which an SBE would be permitted to select from a menu of Federal services. While we are considering providing more flexibility to SBE–FPs in the future, at this point we do not have the operational ability to permit that level of customization. Finally, we considered alternatives under which issuers and other delegated and downstream entities in States with SBE–FPs would not be required to meet FFE standards, or HHS would not participate in enforcement against issuers violating those FFE rules. We believe that applying Federal standards to issuers and their downstream entities for SBE–FPs helps promote consistent minimum standards associated with HealthCare.gov.

For employer choice in the FF–SHOPs, we considered offering an additional employer choice option that would permit an employer to select an actuarial value level of coverage, after which employees could choose from plans available at that level and at the level above it. Recognizing that small group market dynamics differ by State, we decided to seek comment on, but not finalize this option at this time. We also considered requiring all SHOPs to offer the additional employer choice options we proposed, but instead generally opted to maintain State-based SHOPs' flexibility under the current regulations, so that States can decide whether implementing additional employer choice options would be in the best interest of small group market consumers in their State.

We considered requiring QHP issuers to offer standardized options as a condition of participation in the FFEs. However, we believe that markets and Exchanges may be at different stages of readiness for standardized options, and that the cost-sharing structure that HHS specifies may not be well tailored for all States. Similarly, we believe that some issuers may have difficulty offering standardized options in the short run because of operational constraints.

Since releasing the proposed rule, the NAIC has adopted the NAIC Network Adequacy Model Act.[77] We applaud NAIC's work on the Model Act and appreciate the extensive efforts of the Network Adequacy Model Review Subgroup members, as well as the participating stakeholders. As a result of the NAIC Network Adequacy Model Act finalization, we made revisions to this rule to give States more opportunity to implement the NAIC Network Adequacy Model Act. For example, we elected not to finalize our policy requiring each State with an FFE to establish a minimum quantitative network adequacy threshold this year, and stated we would closely monitor States' efforts to implement the provisions of the NAIC Network Adequacy Model Act.

In § 156.1110, we considered maintaining the current approach of aligning with Medicare hospital Conditions of Participation standards and not establishing further regulations at this time for QHP issuers to collect information, such as hospital participation agreements with PSOs, to comply with new patient safety standards for plan years beginning on or after January 1, 2017. However, we decided to adopt this next phase in this final rule because we believe that strengthening patient safety standards and aligning with current, effective patient safety interventions will achieve greater impact for consumers, in terms of health care quality improvement and harm reduction, resulting in higher quality QHPs being offered in the Exchanges. Additionally, we considered an approach that did not include establishing reasonable exceptions to the requirements for a QHP issuer that contracts with a hospital with greater than 50 beds to utilize a patient safety evaluation system and implement a mechanism for comprehensive person-centered hospital discharges, as described in section 1311(h)(1) of the Affordable Care Act. However, we determined that it is important to support national patient safety efforts, promote evidence-based patient safety interventions and allow for flexibility, innovation, and minimal burden for issuers and hospitals.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act, (5 U.S.C. 601, *et seq.*), requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of small entity. HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities.

In this rule, we set forth standards for the risk adjustment, reinsurance, and risk corridors programs, which are intended to stabilize premiums as insurance market reforms are implemented and Exchanges facilitate increased enrollment. Because we believe that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for small entities established by the SBA, we do not believe that an initial regulatory flexibility analysis is required for such firms.

For purposes of the RFA, we expect the following types of entities to be affected by this rule:

- Health insurance issuers.
- Group health plans.

We believe that health insurance issuers and group health plans would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $38.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $32.5 million or less.

Based on data from MLR annual report submissions for the 2014 MLR reporting year, approximately 118 out of 525 issuers of health insurance coverage nationwide had total premium revenue of $38.5 million or less. This estimate may overstate the actual number of small health insurance companies that may be affected, since almost 80 percent of these small companies belong to larger holding groups, and many if not all of these small companies are likely to have non-health lines of business that would result in their revenues exceeding $38.5 million. Based on data from the 2014 MLR and risk corridors annual report submissions, 20 of these 118 potentially small entities had risk corridors payments or charges for the 2014 benefit year. Only one of these entities is estimated to experience a decrease in its risk corridors payment under the provisions in § 153.530(b)(2)(iv), with no impact on its rebate liability. Therefore, we do not expect the provisions of this rule to affect a substantial number of small health insurance issuers or group health plans.

Among the policies established by this rule are policies that could increase the choice of QHPs available to small

[77] *http://www.naic.org/store/free/MDL-74.pdf.*

groups participating in an FF–SHOP, and policies imposing requirements, including information collection requirements, on Navigators, non-Navigator assistance personnel, and certified application counselor organizations. We believe that the effects on small employers participating in an FF–SHOP are difficult to quantify, but will not result in substantial additional burden, since they will simply permit certain small employers greater choice in the QHPs they may make available. The burden estimates for Navigators, non-Navigator assistance personnel, and certified application counselor organizations are described elsewhere in the ICR and RIA sections of this final rule.

F. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a rule that includes any Federal mandate that may result in expenditures in any 1 year by a State, local, or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. Currently that threshold is approximately $144 million. Although we have not been able to quantify all costs, the combined administrative cost and user fee impact on State, local, or Tribal governments and the private sector may be above the threshold. Earlier portions of this RIA constitute our UMRA analysis.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment or reinsurance program. For States electing to operate an Exchange, risk adjustment or reinsurance program, much of the initial cost of creating these programs was funded by Exchange Planning and Establishment Grants. After establishment, Exchanges will be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges may charge user fees to issuers.

In HHS's view, while this rule would not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. For example, in this final rule we have established a number of policies relating to network adequacy and continuity of care for QHPs on FFEs. States have traditionally played a major role in regulating these aspects of health insurance, when offered off the Exchange.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis. Following review of comments from State insurance officials and the NAIC, we have made substantial changes to our network adequacy policies in this final rule.

Throughout the process of developing the proposed and final rule, HHS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

H. Congressional Review Act

This rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Parts 144 and 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 153

Administrative practice and procedure, Health care, Health insurance, Health records, Organization and functions (Government agencies), Reporting and recordkeeping requirements.

45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Health care, Health insurance, Reporting and recordkeeping requirements, State and local governments

45 CFR Part 156

Administrative practice and procedure, Advertising, American Indian/Alaska Natives, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Individuals with disabilities, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 147, 153, 154, 155, 156, and 158 as set forth below.

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 2. Section 144.103 is amended by revising paragraph (1) of the definition of ''Excepted benefits'' and revising the definitions of ''Large employer'' and ''Small employer'' to read as follows:

§ 144.103 Definitions.

* * * * *

Excepted benefits * * *

(1) Group market provisions in 45 CFR part 146, subpart D, is defined in 45 CFR 146.145(b); and

* * * * *

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A State may elect to define large employer by substituting ''101 employees'' for ''51 employees.'' In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

* * * * *

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A State may elect to define small employer by substituting ''100 employees'' for ''50 employees.'' In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

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PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 3. The authority citation for part 147 continues to read as follows:

Authority: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 4. Section 147.102 is amended by revising paragraph (a)(1)(ii) to read as follows:

§ 147.102 Fair health insurance premiums.

(a) * * *

(1) * * *

(ii) Rating area, as established in accordance with paragraph (b) of this section. For purposes of this paragraph (a), rating area is determined—

(A) In the individual market, using the primary policyholder's address.

(B) In the small group market, using the group policyholder's principal business address. For purposes of this paragraph (a)(1)(ii)(B), principal business address means the principal business address registered with the State or, if a principal business address is not registered with the State, or is registered solely for purposes of service of process and is not a substantial worksite for the policyholder's business, the business address within the State where the greatest number of employees of such policyholder works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area, the principal business address for purposes of the network plan is the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the rating area for purposes of the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

* * * * *

■ 5. Section 147.145 is amended by revising paragraphs (b)(2) and (3) and removing paragraphs (d) and (e) to read as follows:

§ 147.145 Student health insurance coverage.

* * * * *

(b) * * *

(2) *Levels of coverage.* The requirement to provide a specific level of coverage described in section 1302(d) of the Affordable Care Act does not apply to student health insurance coverage for policy years beginning on or after July 1, 2016. However, the benefits provided by such coverage must provide at least 60 percent actuarial value, as calculated in accordance with § 156.135 of this subchapter. The issuer must specify in any plan materials summarizing the terms of the coverage the actuarial value and level of coverage (or next lowest level of coverage) the coverage would otherwise satisfy under § 156.140 of this subchapter.

(3) *Single risk pool.* Student health insurance coverage is not subject to the requirements of section 1312(c) of the Affordable Care Act. A health insurance issuer that offers student health insurance coverage may establish one or more separate risk pools for an institution of higher education, if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on a health factor (as described in § 146.121 of this subchapter). However, student health insurance rates must reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool must be actuarially justified.

* * * * *

PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

■ 6. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

■ 7. Section 153.405 is amended by revising paragraph (i) to read as follows:

§ 153.405 Calculation of reinsurance contributions.

* * * * *

(i) *Audits.* HHS or its designee may audit a contributing entity to assess its compliance with the requirements of this subpart. A contributing entity that uses a third party administrator, administrative services-only contractor, or other third party to assist with its obligations under this subpart must ensure that the third party administrator, administrative services-only contractor, or other third party cooperates with any audit under this section.

■ 8. Section 153.510 is amended by adding paragraph (g) to read as follows:

§ 153.510 Risk corridors establishment and payment methodology.

* * * * *

(g) *Adjustment to risk corridors payments and charges.* If an issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual value of cost-sharing reductions calculated under § 156.430(c) of this subchapter for the 2014 benefit year, HHS will make an adjustment to the amount of the issuer's 2015 benefit year risk corridors payment or charge measured by the full difference between the certified estimate of 2014 cost-sharing reductions reported and the actual value of cost-sharing reductions provided as calculated under § 156.430(c) for the 2014 benefit year.

■ 9. Section 153.530 is amended by revising paragraphs (b)(2)(ii) and (iii) and adding paragraph (b)(2)(iv) to read as follows:

§ 153.530 Risk corridors data requirements.

* * * * *

(b) * * *

(2) * * *

(ii) Any reinsurance payments received by the issuer for the non-grandfathered health plans under the transitional reinsurance program established under subpart C of this part;

(iii) A cost-sharing reduction amount equal to the amount of cost-sharing reductions for the benefit year as calculated under § 156.430(c) of this subchapter, to the extent not reimbursed to the provider furnishing the item or service.

(iv) For the 2015 and 2016 benefit years, any difference between—

(A) The sum of unpaid claims reserves and claims incurred but not reported, as set forth in §§ 158.103 and 158.140(a)(2) and (3) of this subchapter, that were reported on the MLR and Risk Corridors Annual Reporting Form for the year preceding the benefit year; and

(B) The actual claims incurred during the year preceding the benefit year and paid between March 31 of the benefit year and March 31 of the year following the benefit year.

* * * * *

■ 10. Section 153.710 is amended by—

■ a. Removing paragraph (d).

■ b. Redesignating paragraphs (e) and (f) as paragraphs (d) and (e), respectively.

■ c. Revising newly redesignated paragraph (e).

■ d. Adding paragraph (f).

■ e. Adding paragraph (g) introductory text and revising paragraphs (g)(1) introductory text, (g)(1)(iii) and (iv), and (g)(2).

■ f. Adding paragraph (g)(3).

The revisions and additions read as follows:

§ 153.710 Data requirements.

* * * * *

(e) *Unresolved discrepancies.* If a discrepancy first identified in a final dedicated distributed data environment report in accordance with paragraph (d)(2) of this section remains unresolved after the issuance of the notification of risk adjustment payments and charges or reinsurance payments under § 153.310(e) or § 153.240(b)(1)(ii), respectively, an issuer of a risk adjustment covered plan or reinsurance-eligible plan may make a request for reconsideration regarding such discrepancy under the process set forth in § 156.1220(a) of this subchapter.

(f) *Evaluation of dedicated distributed data.* If an issuer of a risk adjustment covered plan fails to provide sufficient required data, such that HHS cannot apply the applicable methodology to calculate the risk adjustment payment transfer amount for the risk adjustment covered plan in a timely or appropriate fashion, then HHS will assess a default risk adjustment charge under § 153.740(b). If an issuer of a reinsurance eligible plan fails to provide data sufficient for HHS to calculate reinsurance payments, the issuer will forfeit reinsurance payments for claims it fails to submit.

(1) *Data quantity.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan must provide, in a format and on a timeline specified by HHS, data on its total enrollment and claims counts by market, which HHS may use in evaluating whether the issuer provided access in the dedicated distributed data environment to a sufficient quantity of data to meet reinsurance and risk adjustment data requirements.

(2) *Data quality.* If, following the deadline for submission of data specified in § 153.730, HHS identifies an outlier that would cause the data that a risk adjustment covered plan or a reinsurance-eligible plan made available through a dedicated distributed data environment to fail HHS's data quality thresholds, the issuer may, within 10 calendar days of receiving notification of the outlier, submit an explanation of the outlier for HHS to consider in determining whether the issuer met the reinsurance and risk adjustment data requirements.

(g) *Risk corridors and MLR reporting.* Except as provided in paragraph (g)(3) of this section:

(1) Notwithstanding any discrepancy report made under paragraph (d)(2) of this section, or any request for reconsideration under § 156.1220(a) of this subchapter with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; cost-sharing reduction payment or charge; or risk corridors payment or charge, unless the dispute has been resolved, an issuer must report, for purposes of the risk corridors and MLR programs:

* * * * *

(iii) A cost-sharing reduction amount equal to the actual amount of cost-sharing reductions for the benefit year as calculated under § 156.430(c) of this subchapter, to the extent not reimbursed to the provider furnishing the item or service; and

(iv) For medical loss ratio reporting only, the risk corridors payment to be made or charge assessed by HHS under § 153.510.

(2) An issuer must report during the current MLR and risk corridors reporting year any adjustment made or approved by HHS for any risk adjustment payment or charge, including an assessment of risk adjustment user fees; any reinsurance payment; any cost-sharing reduction payment or charge; or any risk corridors payment or charge before August 15, or the next applicable business day, of the current MLR and risk corridors reporting year unless instructed otherwise by HHS. An issuer must report any adjustment made or approved by HHS for any risk adjustment payment or charge, including an assessment of risk adjustment user fees; any reinsurance payment; any cost-sharing reduction payment or charge; or any risk corridors payment or charge where such adjustment has not been accounted for in a prior MLR and Risk Corridor Annual Reporting Form, in the MLR and Risk Corridors Annual Reporting Form for the following reporting year.

(3) In cases where HHS reasonably determines that the reporting instructions in paragraph (g)(1) or (2) of this section would lead to unfair or misleading financial reporting, issuers must correct their data submissions in a form and manner to be specified by HHS.

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

■ 11. The authority citation for part 154 continues to read as follows:

Authority: Section 2794 of the Public Health Service Act (42 U.S.C. 300gg–94).

■ 12. Section 154.200 is amended by revising paragraph (c)(2) to read as follows:

§ 154.200 Rate increases subject to review.

* * * * *

(c) * * *

(2) For rates filed for single risk pool coverage beginning on or after January 1, 2017, the average increase, including premium rating factors described in § 147.102 of this subchapter, for all enrollees weighted by premium volume for any plan within the product meets or exceeds the applicable threshold.

* * * * *

■ 13. Section 154.215 is amended by revising paragraphs (a) and (b) introductory text and removing and reserving paragraph (c) to read as follows:

§ 154.215 Submission of rate filing justification.

(a) A health insurance issuer must submit to CMS and to the applicable State (if the State accepts such submissions) the information specified below on a form and in a manner prescribed by the Secretary.

(1) For all single risk pool products, including new and discontinuing products, the Unified Rate Review Template, as described in paragraph (d) of this section;

(2) For each single risk pool product that includes a plan that is subject to a rate increase, regardless of the size of the increase, the unified rate review template and actuarial memorandum, as described in paragraph (f) of this section;

(3) For each single risk pool product that includes a plan with a rate increase that is subject to review under § 154.210, all parts of the Rate Filing Justification, as described in paragraph (b) of this section

(b) A Rate Filing Justification includes one or more of the following:

* * * * *

■ 14. Section 154.220 is amended by revising the introductory text and paragraphs (b) introductory text and (b)(1) to read as follows:

§ 154.220 Timing of providing the rate filing justification.

A health insurance issuer must submit applicable sections of the Rate Filing Justification for all single risk pool coverage in the individual or small group market, as follows:

* * * * *

(b) For coverage effective on or after January 1, 2017, by the earlier of the following:

(1) The date by which the State requires submission of a rate filing; or

* * * * *

■ 15. Section 154.230 is amended by revising paragraph (c)(2)(i) to read as follows:

§ 154.230 Submission and posting of Final Justifications for unreasonable rate increases.

* * * * *

(c) * * *

(2) * * *

(i) The information made available to the public by CMS and described in § 154.215(h).

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 16. The authority citation for part 155 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

■ 17. Section 155.20 is amended by—
■ a. Revising paragraph (2) in the definition of ''Applicant''.
■ b. Adding the definitions of ''Federal platform agreement'' and ''Standardized option'' in alphabetical order.
■ c. Revising the definitions of ''Large employer'' and ''Small employer''.

The addition and revisions read as follows:

§ 155.20 Definitions.

* * * * *

Applicant * * *

(2) For SHOP:

(i) An employer seeking eligibility to purchase coverage through the SHOP; or

(ii) An employer, employee, or a former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, seeking eligibility to enroll his or her dependents in a QHP through the SHOP.

* * * * *

Federal platform agreement means an agreement between a State Exchange and HHS under which a State Exchange agrees to rely on the Federal platform to carry out select Exchange functions.

* * * * *

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define large employer by substituting ''101 employees'' for ''51 employees.'' The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

* * * * *

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define small employer by substituting ''100 employees'' for ''50 employees.'' The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

* * * * *

Standardized option means a QHP with a standardized cost-sharing structure specified by HHS in rulemaking and that is offered for sale through an individual market Exchange.

* * * * *

■ 18. Section 155.106 is amended by—
■ a. Revising paragraphs (a) introductory text, (a)(2) and (3), and (b) introductory text.
■ b. Adding paragraphs (a)(4) and (5) and (c).

The revisions and additions read as follows:

§ 155.106 Election to operate an Exchange after 2014.

(a) *Election to operate an Exchange.* Except as provided in paragraph (c) of this section, a State electing to seek approval of its Exchange must:

* * * * *

(2) Submit an Exchange Blueprint application for HHS approval at least 15 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 14 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange;

(4) Develop a plan jointly with HHS to facilitate the transition to a State Exchange; and

(5) If the open enrollment period for the year the State intends to begin operating an SBE has not been established, this deadline must be calculated based on the date open enrollment began or will begin in the year in which the State is submitting the Blueprint application.

(b) *Transition process for State Exchanges that cease operations.* If a State intends to cease operation of its Exchange, HHS will operate the Exchange on behalf of the State. Therefore, a State that intends to cease operations of its Exchange must:

* * * * *

(c) *Process for State Exchanges that seek to utilize the Federal platform for select functions.* A State seeking approval as a State Exchange utilizing the Federal platform to support select functions through a Federal platform agreement under § 155.200(f) must:

(1) If the State Exchange does not have a conditionally approved Exchange Blueprint application, submit one for HHS approval at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP;

(2) If the State Exchange has a conditionally approved Exchange Blueprint application, submit any significant changes to that application for HHS approval, in accordance with § 155.105(e), at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 2 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP, in accordance with HHS rules, as a State Exchange utilizing the Federal platform;

(4) Prior to approval, or conditional approval, of the Exchange Blueprint, execute a Federal platform agreement for utilizing the Federal platform for select functions; and

(5) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.

■ 19. Section 155.170 is amended by revising paragraphs (a)(2) and (3) and (c)(2)(iii) to read as follows:

§ 155.170 Additional required benefits.

(a) * * *

(2) A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits.

(3) The State will identify which State-required benefits are in addition to the EHB.

* * * * *

(c) * * *

(2) * * *

(iii) Reported to the State.

■ 20. Section 155.200 is amended by revising paragraph (a) and adding paragraph (f) to read as follows:

§ 155.200 Functions of an Exchange.

(a) *General requirements.* An Exchange must perform the functions described in this subpart and in subparts D, E, F, G, H, K, M, and O of this part unless the State is approved to operate only a SHOP by HHS under § 155.100(a)(2), in which case the Exchange operated by the State must perform the functions described in subpart H of this part and all applicable provisions of other subparts referenced in that subpart. In a State that is approved to operate only a SHOP, the individual market Exchange operated by HHS in that State will perform the functions described in this subpart and in subparts D, E, F, G, K, M, and O of this part.

* * * * *

(f) *Requirements for State Exchanges on the Federal platform.* (1) A State that receives approval or conditional approval to operate a State Exchange on the Federal platform under § 155.106(c) may meet its obligations under paragraph (a) of this section by relying on Federal services that the Federal government agrees to provide under a Federal platform agreement.

(2) A State Exchange on the Federal platform must establish and oversee requirements for its issuers that are no less strict than the following requirements that are applied to Federally-facilitated Exchange issuers:

(i) Data submission requirements under § 156.122(d)(2) of this subchapter;

(ii) Network adequacy standards under § 156.230 of this subchapter;

(iii) Essential community providers standards under § 156.235 of this subchapter;

(iv) Meaningful difference standards under § 156.298 of this subchapter;

(v) Changes of ownership of issuers requirements under § 156.330 of this subchapter;

(vi) QHP issuer compliance and compliance of delegated or downstream entities requirements under § 156.340(a)(4) of this subchapter; and

(vii) Casework requirements under § 156.1010 of this subchapter.

(3) If a State is not substantially enforcing any requirement listed under § 155.200(f)(2) with respect to a QHP issuer or plan in a State-based Exchange on the Federal platform, HHS may enforce that requirement directly against the issuer or plan by means of plan suppression under § 156.815 of this subchapter.

■ 21. Section 155.205 is amended by—

■ a. Revising paragraphs (a), (b)(1) introductory text, and (d)(1).

■ b. Adding paragraph (b)(7).

The addition and revisions read as follows:

§ 155.205 Consumer assistance tools and programs of an Exchange.

(a) *Call center.* The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section, unless it enters into a Federal platform agreement through which it relies on HHS to carry out call center functions, in which case the Exchange must provide at a minimum a toll-free telephone hotline to respond to requests for assistance and appropriately directs consumers to Federal platform services to apply for, and enroll in, Exchange coverage.

(b) * * *

(1) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools, and at a minimum includes:

* * * * *

(7) A State-based Exchange on the Federal platform must at a minimum maintain an informational Internet Web site that includes the capability to direct consumers to Federal platform services to apply for, and enroll in, Exchange coverage.

* * * * *

(d) * * *

(1) The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in § 155.210. Any individual providing such consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the State, as implemented in the State, prior to providing such assistance or the outreach and education activities specified in paragraph (e) of this section.

* * * * *

■ 22. Section 155.210 is amended by—

■ a. Revising paragraphs (b)(2)(iii) and (iv).

■ b. Adding paragraphs (b)(2)(v) through (ix).

■ c. Revising paragraphs (d)(6) and (e)(6)(i).

■ d. In paragraph (e)(7), removing the period at the end of the paragraph and adding a semicolon in its place.

■ e. Adding paragraphs (e)(8) and (9).

The revisions and additions read as follows:

§ 155.210 Navigator program standards.

* * * * *

(b) * * *

(2) * * *

(iii) The range of QHP options and insurance affordability programs;

(iv) The privacy and security standards applicable under § 155.260;

(v) In an Exchange that requires Navigators to provide the assistance specified in paragraph (e)(9)(i) of this section, the process of filing Exchange eligibility appeals;

(vi) In an Exchange that requires Navigators to provide the assistance specified in paragraph (e)(9)(ii) of this section, general concepts regarding exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, including the application process for exemptions granted through the Exchange, and IRS resources on exemptions;

(vii) In an Exchange that requires Navigators to provide the assistance specified in paragraph (e)(9)(iii) of this section, the Exchange-related components of the premium tax credit reconciliation process and IRS resources on this process;

(viii) In an Exchange that requires Navigators to provide the assistance specified in paragraph (e)(9)(iv) of this section, basic concepts and rights related to health coverage and how to use it; and

(ix) In an Exchange that requires Navigators to provide the assistance specified in paragraph (e)(9)(v) of this section, providing referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, and premium tax credit reconciliations.

* * * * *

(d) * * *

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (d)(6), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses.

* * * * *

(e) * * *

(6) * * *

(i) Are informed, prior to receiving assistance, of the functions and responsibilities of Navigators, including that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators;

* * * * *

(8) Provide targeted assistance to serve underserved or vulnerable populations, as identified by the Exchange, within the Exchange service area.

(i) In a Federally-facilitated Exchange, this paragraph (e)(8) will apply beginning with the Navigator grant application process for Navigator grants awarded in 2018. The Federally-facilitated Exchange will identify populations as vulnerable or underserved that are disproportionately without access to coverage or care, or that are at a greater risk for poor health outcomes, in the funding opportunity announcement for its Navigator grants, and applicants for those grants will have an opportunity to propose additional vulnerable or underserved populations in their applications for the Federally-facilitated Exchange's approval.

(ii) [Reserved]

(9) The Exchange may require or authorize Navigators to provide information and assistance with any of the following topics. In Federally-facilitated Exchanges, Navigators are authorized to provide information and assistance with any of the following topics and will be required to provide information and assistance with all of the following topics under Navigator grants awarded in 2018 or any later year.

(i) Understanding the process of filing Exchange eligibility appeals;

(ii) Understanding and applying for exemptions from the individual shared responsibility payment that are granted through the Exchange, understanding the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to claim them, and understanding the availability of IRS resources on this topic;

(iii) The Exchange-related components of the premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, and premium tax credit reconciliations.

* * * * *

■ 23. Section 155.215 is amended by revising paragraphs (b)(1)(i) and (g)(1) to read as follows:

§ 155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant.

* * * * *

(b) * * *

(1) * * *

(i) Obtain certification by the Exchange prior to carrying out any consumer assistance functions or outreach and education activities under § 155.205(d) and (e) or § 155.210;

* * * * *

(g) * * *

(1) Are informed, prior to receiving assistance, of the functions and responsibilities of non-Navigator assistance personnel, including that non-Navigator assistance personnel are not acting as tax advisers or attorneys when providing assistance as non-Navigator assistance personnel and cannot provide tax or legal advice within their capacity as non-Navigator assistance personnel;

* * * * *

■ 24. Section 155.220 is amended by—

■ a. Revising paragraph (c)(1) and (3), (f)(4), (g)(2)(ii), and (g)(3) and (4);

■ b. Adding new paragraphs (c)(4)(i)(F), (c)(5), (g)(5) and (6), (j), (k), and (l).

The revisions and additions read as follows:

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(c) * * *

(1) The agent or broker ensures the applicant's completion of an eligibility

verification and enrollment application through the Exchange Internet Web site as described in § 155.405, or ensures that the eligibility application information is submitted for an eligibility determination through the Exchange-approved Web service subject to meeting the requirements in paragraphs (c)(3)(ii) and (c)(4)(i)(F) of this section;

* * * * *

(3)(i) When an Internet Web site of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must:

(A) Disclose and display all QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of § 155.205(b)(1) and (c), and to the extent that not all information required under § 155.205(b)(1) is displayed on the agent or broker's Internet Web site for a QHP, prominently display a standardized disclaimer provided by HHS stating that information required under § 155.205(b)(1) for the QHP is available on the Exchange Web site, and provide a Web link to the Exchange Web site;

(B) Provide consumers the ability to view all QHPs offered through the Exchange;

(C) Not provide financial incentives, such as rebates or giveaways;

(D) Display all QHP data provided by the Exchange;

(E) Maintain audit trails and records in an electronic format for a minimum of ten years;

(F) Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in § 155.205(b) instead at any time; and

(G) For the Federally-facilitated Exchange, prominently display a standardized disclaimer provided by HHS, and provide a Web link to the Exchange Web site.

(ii) When an Internet Web site of an agent or broker is used to complete the Exchange eligibility application, at a minimum, the Internet Web site must:

(A) Comply with the requirements in paragraph (c)(3)(i) of this section;

(B) Use exactly the same eligibility application language as appears in the FFE Single Streamlined Application required in § 155.405, unless HHS approves a deviation;

(C) Ensure that all necessary information for the consumer's applicable eligibility circumstances are submitted through the Exchange-approved web service; and

(D) Ensure that the process used for consumers to complete the eligibility application complies with all applicable Exchange standards, including §§ 155.230 and 155.260(b).

(4) * * *

(i) * * *

(F) When an Internet Web site of an agent or broker is used to complete the Exchange eligibility application, obtain HHS approval verifying that all requirements in this section are met.

* * * * *

(5) HHS or its designee may periodically monitor and audit an agent or broker under this subpart to assess its compliance with the applicable requirements of this section.

* * * * *

(f) * * *

(4) When the agreement between the agent or broker and the Exchange under paragraph (d) of this section is terminated under paragraph (f) of this section, the agent or broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under § 155.260(b) will also be terminated through the termination without cause process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(g) * * *

(2) * * *

(ii) Any term or condition of the agreement with the Federally-facilitated Exchanges required under paragraph (d) of this section, or any term or condition of the agreement with the Federally-facilitated Exchange required under § 155.260(b);

* * * * *

(3) HHS will notify the agent or broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and after 30 days from the date of the notice, may terminate the agreement for cause if the matter is not resolved to the satisfaction of HHS.

(4) After the period in paragraph (g)(3) of this section has elapsed and the agreement under paragraph (d) of this section is terminated, the agent or broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under § 155.260(b)(2) will also be terminated through the process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(5) Fraud or abusive conduct—

(i)(A) If HHS reasonably suspects that an agent or broker may have may have engaged in fraud, or in abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant or in connection with an Exchange enrollment or application, HHS may temporarily suspend the agent's or broker's agreements required under paragraph (d) of this section and under § 155.260(b) for up to 90 calendar days. Suspension will be effective on the date of the notice that HHS sends to the agent or broker advising of the suspension of the agreements.

(B) The agent or broker may submit evidence in a form and manner to be specified by HHS, to rebut the allegation during this 90-day period. If the agent or broker submits such evidence during the suspension period, HHS will review the evidence and make a determination whether to lift the suspension within 30 days of receipt of such evidence. If the rebuttal evidence does not persuade HHS to lift the suspension, or if the agent or broker fails to submit rebuttal evidence during the suspension period, HHS may terminate the agent's or broker's agreements required under paragraph (d) of this section and under § 155.260(b) for cause under paragraph (g)(5)(ii) of this section.

(ii) If there is a finding or determination by a Federal or State entity that an agent or broker engaged in fraud, or abusive conduct that may result in imminent or ongoing consumer harm, using personally identifiable information of Exchange enrollees or applicants or in connection with an Exchange enrollment or application, HHS will terminate the agent's or broker's agreements required under paragraph (d) of this section and under § 155.260(b) for cause. The termination will be effective starting on the date of the notice that HHS sends to the agent or broker advising of the termination of the agreements.

(iii) During the suspension period under paragraph (g)(5)(i) of this section and following termination of the agreements under paragraph (g)(5)(i)(B) or (g)(5)(ii) of this section, the agent or broker will not be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with a Federally-facilitated Exchange.

(6) The State department of insurance or equivalent State agent or broker licensing authority will be notified by HHS in cases of suspensions or terminations effectuated under this paragraph (g).

* * * * *

(j) *Federally-facilitated Exchange standards of conduct.* (1) An agent or broker that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs sold through a Federally-facilitated Exchange, must—

(i) Have executed the required agreement under paragraph § 155.260(b);

(ii) Be registered with the Federally-facilitated Exchanges under paragraph (d)(1) of this section; and

(iii) Comply with the standards of conduct in paragraph (j)(2) of this section.

(2) Standards of conduct. An individual or entity described in paragraph (j)(1) of this section must—

(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading or coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

(ii) Provide the Federally-facilitated Exchanges with correct information under section 1411(b) of the Affordable Care Act;

(iii) Obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment through a Federally-facilitated Exchange, or assisting the individual in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs;

(iv) Protect consumer personally identifiable information according to § 155.260(b)(3) and the agreement described in § 155.260(b)(2); and

(v) Comply with all applicable Federal and State laws and regulations.

(3) If an agent or broker fails to provide correct information, he or she will nonetheless be deemed in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent or broker acted in good faith.

(k) *Penalties other than termination of the agreement with the Federally-facilitated Exchanges.* (1) If HHS determines that an agent or broker has failed to comply with the requirements of this section, in addition to any other available remedies, that agent or broker—

(i) May be denied the right to enter into agreements with the Federally-facilitated Exchanges in future years; and

(ii) May be subject to civil money penalties as described in § 155.285.

(2) HHS will notify the agent or broker of the proposed imposition of penalties under paragraph (k)(1)(i) of this section and, after 30 calendar days from the date of the notice, may impose the penalty if the agent or broker has not requested a reconsideration under paragraph (h) of this section. The proposed imposition of penalties under paragraph (k)(1)(ii) of this section will follow the process outlined under § 155.285.

(l) *Application to State-Based Exchanges using a Federal platform.* An agent or broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an State-Based Exchange using a Federal platform, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through an State-Based Exchange using a Federal platform must comply with all applicable Federally-facilitated Exchange standards in this section.

■ 25. Section 155.222 is amended by—

■ a. Revising the section heading.

■ b. Revising paragraphs (a)(1) and (2), (b)(1) through (5), and (d).

■ c. Adding new paragraph (b)(6).

The revisions and addition read as follows:

§ 155.222 Standards for HHS-approved vendors of Federally-facilitated Exchange training for agents and brokers.

(a) * * *

(1) A vendor must be approved by HHS, in a form and manner to be determined by HHS, to have its training program recognized for agents and brokers assisting with or facilitating enrollment in individual market or SHOP coverage through the Federally-facilitated Exchanges consistent with § 155.220.

(2) As part of the training program, the vendor must require agents and brokers to provide identifying information and successfully complete the required curriculum.

* * * * *

(b) * * *

(1) Submit a complete and accurate application by the deadline established by HHS, which includes demonstration of prior experience with successfully conducting online training, as well as providing technical support to a large customer base.

(2) Adhere to HHS specifications for content, format, and delivery of training, which includes offering continuing education units (CEUs) for at least five States in which a Federally-facilitated Exchange or State-Based Exchange using a Federal platform is operating.

(3) Collect, store, and share with HHS training completion data from agent and broker users of the vendor's training in a manner, format, and frequency specified by HHS, and protect all data from agent and broker users of the vendor's training in accordance with applicable privacy and security requirements.

(4) Execute an agreement with HHS, in a form and manner to be determined by HHS, which requires the vendor to comply with applicable HHS guidelines for implementing the training and interfacing with HHS data systems, and the use of all data collected.

(5) Permit any individual who holds a valid State license or equivalent State authority to sell health insurance products to access the vendor's training.

(6) Provide technical support to agent and broker users of the vendor's training as specified by HHS.

* * * * *

(d) *Monitoring.* HHS may periodically monitor and audit vendors approved under this subpart, and their records related to the training functions described in this section, to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS

determines that an HHS-approved vendor is not in compliance with the standards required in paragraph (b) of this section, the vendor may be removed from the approved list described in paragraph (c) of this section and may be required by HHS to cease performing the training functions described under this subpart.

* * * * *

■ 26. Section 155.225 is amended by adding paragraph (b)(1)(iii) and revising paragraphs (f)(1) and (g)(4) to read as follows:

§ 155.225 Certified application counselors.

* * * * *

(b) * * *

(1) * * *

(iii) Provides data and information to the Exchange regarding the number and performance of its certified application counselors and regarding the consumer assistance provided by its certified application counselors, upon request, in the form and manner specified by the Exchange. Beginning for the third quarter of calendar year 2017, in a Federally-facilitated Exchange, organizations designated by the Exchange must submit quarterly reports that include, at a minimum, data regarding the number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance in applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP.

* * * * *

(f) * * *

(1) Are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

* * * * *

(g) * * *

(4) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (g)(4), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses;

* * * * *

■ 27. Section 155.260 is amended by revising paragraph (a)(1) introductory text to read as follows:

§ 155.260 Privacy and security of personally identifiable information.

(a) * * *

(1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in § 155.300; or determining eligibility for exemptions from the individual shared responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

* * * * *

■ 28. Section 155.280 is amended by revising paragraph (a) to read as follows:

§ 155.280 Oversight and monitoring of privacy and security requirements.

(a) *General.* HHS will oversee and monitor the Federally-facilitated Exchanges, State-based Exchanges on the Federal platform, and non-Exchange entities required to comply with the privacy and security standards established and implemented by a Federally-facilitated Exchange pursuant to § 155.260 for compliance with those standards. HHS will oversee and monitor State Exchanges for compliance with the standards State Exchanges establish and implement pursuant to § 155.260. State Exchanges will oversee and monitor non-Exchange entities required to comply with the privacy and security standards established and implemented by a State Exchange in accordance to § 155.260.

* * * * *

■ 29. Section 155.302 is amended by revising paragraph (a)(1) to read as follows:

§ 155.302 Options for conducting eligibility determinations.

(a) * * *

(1) Directly, through contracting arrangements in accordance with § 155.110(a), or as a State-based Exchange on the Federal platform through a Federal platform agreement under which HHS carries out eligibility determinations and other requirements contained within this subpart; or

* * * * *

■ 30. Section 155.310 is amended by revising paragraphs (h) introductory text and (h)(2) to read as follows:

§ 155.310 Eligibility process.

* * * * *

(h) *Notice of an employee's receipt of advance payments of the premium tax credit and cost-sharing reductions to an employer.* The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions in accordance with § 155.305(g) or § 155.350(a) and enrollment by the employee in a qualified health plan through the Exchange. Such notice must:

* * * * *

(2) Indicate that the employee has been determined eligible advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange;

* * * * *

■ 31. Section 155.320 is amended by revising paragraphs (c)(3)(vi) introductory text and (d)(3) and adding paragraph (d)(4) to read as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(3) * * *

(vi) *Alternate verification process for decreases in annual household income estimates and for situations in which tax return data is unavailable.* If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than a reasonable threshold below the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by following the procedures specified in paragraph

(c)(3)(vi)(A) through (G) of this section. For the purposes of this paragraph (c)(3)(vi), a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount. The Exchange's threshold is subject to approval by HHS.

* * * * *

(d) * * *

(3) *Verification procedures.* (i) If an applicant's attestation is not reasonably compatible with the information obtained by the Exchange as specified in paragraphs (d)(2)(i) through (iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f).

(ii) Except as specified in paragraph (d)(3)(i) or (d)(4)(i) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) of this section without further verification.

(4) *Alternate procedures.* For any benefit year for which it does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (iii) of this section, the Exchange must follow the procedures specified in paragraph (d)(4)(i) of this section or, for benefit years 2016 and 2017, the Exchange may follow the procedures specified in paragraph (d)(4)(ii) of this section. For purposes of this paragraph (d)(4), the Exchange reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, the Exchange is able to obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to the Exchange and that has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described under paragraph (d)(2)(i) of this section.

(i) Select a statistically significant random sample of applicants for whom the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (iii) of this section and—

(A) Provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of the eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified;

(C) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange must determine the applicant's eligibility based on such information and in accordance with the effective dates specified in § 155.330(f), and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in § 155.310(g) and (h);

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(4)(i)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange must determine the applicant's eligibility based on his or her attestation regarding coverage provided by that employer.

(G) To carry out the process described in paragraph (d)(4)(i) of this section, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

(ii) Establish an alternative process approved by HHS.

* * * * *

■ 32. Section 155.335 is amended by revising paragraph (j) to read as follows:

§ 155.335 Annual eligibility redetermination.

* * * * *

(j) *Re-enrollment.* If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination and—

(1) The product under which the QHP in which he or she is enrolled remains available through the Exchange for renewal, consistent with § 147.106 of this subchapter, such enrollee will have his or her enrollment through the Exchange in a QHP under that product renewed, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(1) occurs under the same product (except as provided in paragraph (j)(1)(iii)(A) of this section) in which the enrollee was enrolled, as follows:

(i) The enrollee's coverage will be renewed in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange.

(ii) If the enrollee's current QHP is not available through the Exchange, the enrollee's coverage will be renewed in a QHP at the same metal level as the enrollee's current QHP within the same product.

(iii) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP and—

(A) The enrollee's current QHP is a silver level plan, the enrollee will be re-enrolled in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product. If no such silver level QHP is available for enrollment through the Exchange, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product;

(B) The enrollee's current QHP is not a silver level plan, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product; or

(iv) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee's coverage will be renewed in any other QHP offered under the product in which the enrollee's current

QHP is offered in which the enrollee is eligible to enroll.

(2) No plans under the product under which the QHP in which he or she is enrolled are available through the Exchange for renewal, consistent with § 147.106 of this subchapter, such enrollee may be enrolled in a QHP under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(2) occurs as follows:

(i) The enrollee will be re-enrolled in a QHP at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product;

(ii) If the issuer does not offer another QHP at the same metal level as the enrollee's current QHP, the enrollee will be re-enrolled in a QHP that is one metal level higher or lower than the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or

(iii) If the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee will be re-enrolled in any other QHP offered by the same issuer in which the enrollee is eligible to enroll.

(3) No QHPs from the same issuer are available through the Exchange, the enrollee may be enrolled through the Exchange in a QHP issued by a different issuer, to the extent permitted by applicable State law, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(3) occurs as follows:

(i) As directed by the applicable State regulatory authority; or

(ii) If the applicable State regulatory authority declines to provide direction, in a similar QHP from a different issuer, as determined by the Exchange.

* * * * *

■ 33. Section 155.400 is amended by revising paragraph (e) and adding paragraphs (g) and (h) to read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(e) *Premium payment.* Exchanges may, and the Federally-facilitated Exchange will, require payment of a binder payment to effectuate an enrollment or to add coverage retroactively to an already effectuated enrollment. Exchanges may, and the Federally-facilitated Exchange will, establish a standard policy for setting premium payment deadlines:

(1) In a Federally-facilitated Exchange:

(i) For prospective coverage to be effectuated under regular coverage effective dates, as provided for in §§ 155.410(f) and 155.420(b)(1), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date, and no later than 30 calendar days from the coverage effective date.

(ii) For prospective coverage to be effectuated under special effective dates, as provided for in § 155.420(b)(2), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later.

(iii) For coverage to be effectuated under retroactive effective dates, as provided for in § 155.420(b)(2), the binder payment must consist of the premium due for all months of retroactive coverage through the first prospective month of coverage, and the deadline for making the binder payment must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction. If only the premium for one month of coverage is paid, only prospective coverage should be effectuated, in accordance with regular effective dates.

(2) [Reserved]

* * * * *

(g) *Premium payment threshold.* Exchanges may, and the Federally-facilitated Exchange will, allow issuers to implement, a premium payment threshold policy under which issuers can consider enrollees to have paid all amounts due if the enrollees pay an amount sufficient to maintain a percentage of total premium paid out of the total premium owed equal to or greater than a level prescribed by the issuer, provided that the level is reasonable and that the level and the policy are applied in a uniform manner to all enrollees. If an applicant or enrollee satisfies the premium payment threshold policy, the issuer may:

(1) Effectuate an enrollment based on payment of the binder payment under paragraph (e) of this section.

(2) Avoid triggering a grace period for non-payment of premium, as described by § 156.270(d) of this subchapter or a grace period governed by State rules.

(3) Avoid terminating the enrollment for non-payment of premium as, described by §§ 156.270(g) of this subchapter and 155.430(b)(2)(ii)(A) and (B).

(h) *Requirements.* A State Exchange may rely on HHS to carry out the requirements of this section and other requirements contained within this subpart through a Federal platform agreement.

■ 34. Section 155.410 is amended by revising paragraphs (e)(2) and (f)(2) and adding paragraphs (e)(3) to read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(e) * * *

(2) For the benefit years beginning on January 1, 2016, on January 1, 2017, and on January 1, 2018, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(3) For the benefit years beginning on January 1, 2019 and beyond, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

(f) * * *

(2) For benefit years beginning on or after January 1, 2016, the Exchange must ensure that coverage is effective—

(i) January 1, for QHP selections received by the Exchange on or before December 15 of the calendar year preceding the benefit year.

(ii) February 1, for QHP selections received by the Exchange from December 16 of the calendar year preceding the benefit year through January 15 of the benefit year.

(iii) March 1, for QHP selections received by the Exchange from January 16 through January 31 of the benefit year.

* * * * *

■ 35. Section 155.430 is amended by—

■ a. Adding paragraph (b)(1)(iv).

■ b. Revising paragraphs (b)(2)(ii)(A).

■ c. Redesignating paragraph (b)(2)(vi) as paragraph (b)(2)(vii).

■ d. Adding paragraphs (b)(2)(vi) and (d)(9), (10), (11), and (12).

The additions and revision read as follows:

§ 155.430 Termination of Exchange enrollment or coverage.

* * * * *

(b) * * *

(1) * * *

(iv) The Exchange must permit an enrollee to retroactively terminate or cancel his or her coverage or enrollment in a QHP in the following circumstances:

(A) The enrollee demonstrates to the Exchange that he or she attempted to terminate his or her coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate his or her coverage or enrollment through the Exchange, and requests retroactive termination within 60 days after he or she discovered the technical error.

(B) The enrollee demonstrates to the Exchange that his or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this paragraph (b)(1)(iv)(B), misconduct includes the failure to comply with applicable standards under this part, part 156 of this subchapter, or other applicable Federal or State requirements as determined by the Exchange.

(C) The enrollee demonstrates to the Exchange that he or she was enrolled in a QHP without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(2) * * *

(ii) * * *

(A) The exhaustion of the 3-month grace period, as described in § 156.270(d) and (g) of this subchapter, required for enrollees, who when first failing to timely pay premiums, are receiving advance payments of the premium tax credit.

* * * * *

(vi) The enrollee was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange.

* * * * *

(d) * * *

(9) In case of a retroactive termination in accordance with paragraph (b)(1)(iv)(A) of this section, the termination date will be no sooner than 14 days after the date that the enrollee can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless the issuer agrees to an earlier effective date as set forth in paragraph (d)(2)(iii) of this section.

(10) In case of a retroactive cancellation or termination in accordance with paragraph (b)(1)(iv)(B) or (C) of this section, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

(11) In the case of cancellation in accordance with paragraph (b)(2)(vi) of this section, the Exchange may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent and following reasonable notice to the enrollee (where possible). The termination date will be the original coverage effective date.

(12) In the case of retroactive cancellations or terminations in accordance with paragraphs (b)(1)(iv)(A), (B) and (C) of this section, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by the Exchange based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

* * * * *

■ 36. Section 155.505 is amended by adding paragraphs (b)(1)(iii) and (b)(5) and revising paragraph (b)(4) to read as follows:

§ 155.505 General eligibility appeals requirements.

* * * * *

(b) * * *

(1) * * *

(iii) A determination of eligibility for an enrollment period, made in accordance with § 155.305(b);

* * * * *

(4) A denial of a request to vacate dismissal made by a State Exchange appeals entity in accordance with § 155.530(d)(2), made under paragraph (c)(2)(i) of this section; and

(5) An appeal decision issued by a State Exchange appeals entity in accordance with § 155.545(b), consistent with § 155.520(c).

* * * * *

■ 37. Section 155.510 is amended by revising paragraph (a)(1) to read as follows:

§ 155.510 Appeals coordination.

(a) * * *

(1) Minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an insurance affordability program or eligibility appeals process, unless the appeals entity, Exchange, or agency does not have access to the information or documentation and cannot reasonably obtain it, and such information is necessary to properly adjudicate an appeal;

* * * * *

■ 38. Section 155.520 is amended by adding paragraph (d)(2)(i)(D) to read as follows:

§ 155.520 Appeal requests.

* * * * *

(d) * * *

(2) * * *

(i) * * *

(D) That, in the event the appeal request is not valid due to failure to submit by the date determined under paragraph (b) or (c) of this section, as applicable, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe determined by the appeals entity that failure to timely submit was due to exceptional circumstances and should not preclude the appeal.

* * * * *

■ 39. Section 155.530 is amended by revising paragraph (a)(4) to read as follows:

§ 155.530 Dismissals.

(a) * * *

(4) Dies while the appeal is pending, except if the executor, administrator, or other duly authorized representative of the estate requests to continue the appeal.

* * * * *

■ 40. Section 155.535 is amended by revising paragraphs (a) introductory text and (b) to read as follows:

§ 155.535 Informal resolution and hearing requirements.

(a) *Informal resolution.* The HHS appeals process will provide an opportunity for informal resolution and a hearing in accordance with the requirements of this section. A State Exchange appeals entity may also provide an informal resolution process prior to a hearing. Any information resolution process must meet the following requirements:

* * * * *

(b) *Notice of hearing.* When a hearing is scheduled, the appeals entity must

send written notice to the appellant and the appellant's authorized representative, if any, of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date unless—

(1) The appellant requests an earlier hearing date; or

(2) A hearing date sooner than 15 days is necessary to process an expedited appeal, as described in § 155.540(a), and the appeals entity has contacted the appellant to schedule a hearing on a mutually agreed upon date, time, and location or format.

* * * * *

■ 41. Section 155.545 is amended by revising paragraphs (b)(1) and (c)(1)(i) and (ii) to read as follows:

§ 155.545 Appeal decisions.

* * * * *

(b) * * *

(1) Must issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request under § 155.520(b) or (c) is received, as administratively feasible.

* * * * *

(c) * * *

(1) * * *

(i) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with § 155.330(f)(2), (3), (4), or (5), if applicable; or

(ii) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal, at the option of the appellant.

* * * * *

■ 42. Section 155.555 is amended by revising paragraphs (e)(1) introductory text and (l) to read as follows:

§ 155.555 Employer appeals process.

* * * * *

(e) * * *

(1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (d)(1)(iii) of this section, the Exchange must promptly transmit via secure electronic interface to the appeals entity—

* * * * *

(l) *Implementation of the appeal decision.* After receipt of the notice under paragraph (k)(3) of this section, if the appeal decision affects the employee's eligibility, the Exchange must promptly:

(1) Redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable, in accordance with the standards specified in § 155.305; or

(2) Notify the employee of the requirement to report changes in eligibility as described in § 155.330(b)(1).

* * * * *

■ 43. Section 155.605 is amended by—

■ a. In paragraph (b), removing the reference ''paragraphs (c)(2), (f)(2), and (g) of this section'' and adding in its place the reference ''paragraphs (c)(2) and (d) of this section'';

■ b. Removing paragraphs (d), (e), and (f);

■ c. Redesignating paragraph (g) as paragraph (d);

■ d. Revising newly redesignated paragraph (d); and

■ e. Adding paragraph (e).

The revision and addition read as follows:

§ 155.605 Eligibility standards for exemptions.

* * * * *

(d) *Hardship*—(1) *General.* The Exchange must grant a hardship exemption to an applicant eligible for an exemption for at least the month before, the month or months during which, and the month after a specific event or circumstance, if the Exchange determines that:

(i) He or she experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan;

(ii) The expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or

(iii) He or she has experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan.

(2) *Lack of affordable coverage based on projected income.* The Exchange must determine an applicant eligible for an exemption for a month or months during which he or she, or another individual the applicant attests will be included in the applicant's family, as defined in 26 CFR 1.36B–1(d), is unable to afford coverage in accordance with the standards specified in section 5000A(e)(1) of the Code, provided that—

(i) Eligibility for this exemption is based on projected annual household income;

(ii) An eligible employer-sponsored plan is only considered under paragraphs (d)(4)(iii) and (iv) of this section if it meets the minimum value standard described in § 156.145 of this subchapter.

(iii) For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage such that—

(A) An individual who uses tobacco is treated as not earning any premium incentive related to participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan;

(B) Wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned;

(C) In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

(D) In the case of an individual who is eligible to purchase coverage under an eligible employer-sponsored plan as a member of the employee's family, as defined in 26 CFR 1.36B–1(d), the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all other individuals who are included in the employee's family who have not otherwise been granted an exemption through the Exchange.

(iv) For an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage in accordance with section 5000A(e)(1)(B)(ii) of the Code, inclusive of all members of the family, as defined in 26 CFR 1.36B–1(d), who have not otherwise been granted an exemption through the Exchange and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan, in accordance with paragraph (d)(4)(ii) of this section; and

(v) The applicant applies for this exemption prior to the last date on which he or she could enroll in a QHP through the Exchange for the month or months of a calendar year for which the exemption is requested.

(vi) The Exchange must make an exemption in this category available prospectively, and provide it for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

(3) *Ineligible for Medicaid based on a State's decision not to expand.* The Exchange must determine an applicant eligible for an exemption for a calendar year if he or she would be determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act.

(e) *Eligibility for an exemption through the IRS.* Hardship exemptions in this paragraph (e) can be claimed on a Federal income tax return without obtaining an exemption certificate number. The IRS may allow an individual to claim the hardship exemptions described in this paragraph (e) without requiring an exemption certificate number from the Exchange.

(1) *Filing threshold.* The IRS may allow an applicant to claim an exemption specified in HHS Guidance published September 18, 2014, entitled, ''Shared Responsibility Guidance—Filing Threshold Hardship Exemption,'' and in IRS Notice 2014–76, section B (see *https://www.cms.gov/cciio/*).

(2) *Self-only coverage in an eligible employer-sponsored plan.* The IRS may allow an applicant to claim an exemption specified in HHS Guidance published November 21, 2014, entitled, ''Guidance on Hardship Exemptions for Persons Meeting Certain Criteria,'' and in IRS Notice 2014–76, section A (see *https://www.cms.gov/cciio/*).

(3) *Eligible for services through an Indian health care provider.* The IRS may allow an applicant to claim the exemption specified in HHS Guidance published September 18, 2014, entitled, ''Shared Responsibility Guidance—Exemption for Individuals Eligible for Services through an Indian Health Care Provider,'' and in IRS Notice 2014–76, section E (see *https://www.cms.gov/cciio/*).

(4) *Ineligible for Medicaid based on a State's decision not to expand.* The IRS may allow an applicant to claim the exemption specified in HHS Guidance published November 21, 2014, entitled, ''Guidance on Hardship Exemptions for Persons Meeting Certain Criteria,'' and in IRS Notice 2014–76, section F (see *https://www.cms.gov/cciio/*).

■ 44. Section 155.610 is amended by revising paragraph (h)(1) and adding paragraph (k) to read as follows:

§ 155.610 Eligibility process for exemptions.

* * * * *

(h) * * *

(1) Except for the exemptions described in § 155.605(c) and (d), after December 31 of a given calendar year, the Exchange may decline to accept an application for an exemption that is available retrospectively for months for such calendar year, and must provide information to individuals regarding how to claim an exemption through the tax filing process.

* * * * *

(k) *Incomplete application.* (1) If an applicant submits an application that does not include sufficient information for the Exchange to conduct a determination for eligibility of an exemption the Exchange must—

(i) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and

(ii) Provide the applicant with a period of no less than 30 and no more than 90 days, in the reasonable discretion of the Exchange, from the date on which the notice described in paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange; and

(iii) Not proceed with the applicant's eligibility determination during the period described in paragraph (k)(2) of this section.

(2) If the Exchange does not receive the requested information within the time allotted in paragraph (k)(1)(ii) of this section, the Exchange must notify the applicant in writing that the Exchange cannot process the application and provide appeal rights to the applicant.

■ 45. Section 155.615 is amended by—

■ a. Removing paragraphs (c), (d), and (e).

■ b. Redesignating paragraphs (f), (g), (h), (i), (j), and (k) as paragraphs (c), (d), (e), (f), (g), and (h), respectively.

■ c. Revising the paragraph heading for newly redesignated paragraph (c) and paragraph (c)(1).

■ d. Removing and reserving newly redesignated paragraph (c)(3).

The revision and addition read as follows:

§ 155.615 Verification process related to eligibility for exemptions.

* * * * *

(c) *Verification related to exemption for hardship*—(1) *In general.* For any applicant who requests an exemption based on hardship, except for the hardship exemptions described in § 155.605(d)(1)(i) and (iv), the Exchange must verify whether he or she has experienced the hardship to which he or she is attesting.

* * * * *

■ 46. Section 155.625 is amended by revising paragraphs (a)(2) and (b) and adding paragraph (c) to read as follows:

§ 155.625 Options for conducting eligibility determinations for exemptions.

(a) * * *

(2) By use of the HHS service under paragraph (b) of this section.

(b) *Use of HHS service.* Notwithstanding the requirements of this subpart, the Exchange may adopt an exemption eligibility determination made by HHS.

(c) *Administration of hardship exemption based on affordability.* States may choose to administer the hardship exemption under § 155.605(d)(2) only and delegate to HHS all other exemption determinations generally administered by HHS.

■ 47. Section 155.705 is amended by—

■ a. Adding paragraphs (b)(3)(viii), (ix), and (x).

■ b. In paragraph (b)(4)(ii)(B), removing the semicolon and adding a colon in its place.

■ c. Adding paragraphs (b)(4)(ii)(B)(*1*) and (*2*).

■ d. Revising paragraphs (b)(4)(ii)(C)(*2*) and (b)(11)(ii)(A), (B), (C), and (D).

■ e. Removing paragraph (b)(11)(ii)(E).

The revisions and additions read as follows:

§ 155.705 Functions of a SHOP.

* * * * *

(b) * * *

(3) * * *

(viii) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of at least the two methods to make QHPs available to qualified employees and their dependents described in paragraphs (b)(3)(viii)(A) and (B) of this section, and may also provide a qualified employer with a choice of a third method to make QHPs available to qualified employees and their dependents as described in paragraph (b)(3)(viii)(C) of this section.

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section;

(B) The employer may choose a single QHP; or

(C) The employer may offer its qualified employees a choice of all QHPs offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in section 1302(d)(1) of the Affordable Care Act and implemented in § 156.140(b) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this

additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(ix) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of at least the two methods to make stand-alone dental plans available to qualified employees and their dependents described in paragraphs (b)(3)(ix)(A) and (B) of this section, and may also provide a qualified employer with a choice of a third method to make stand-alone dental plans available to qualified employees and their dependents as described in paragraph (b)(3)(ix)(C) of this section.

(A) The employer may choose to make available a single stand-alone dental plan;

(B) The employer may choose to make available all stand-alone dental plans offered through a Federally-facilitated SHOP at a level of coverage as described in § 156.150(b)(2) of this subchapter; or

(C) The employer may offer its qualified employees a choice of all stand-alone dental plans offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in § 156.150(b)(2) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(x) States operating a State-based Exchange utilizing the Federal platform for SHOP enrollment functions will have the same employer choice models available as States with a Federally-facilitated SHOP, except that a State with a State-based Exchange utilizing the Federal platform for SHOP enrollment functions may decide against offering the employer choice models specified in paragraphs (b)(3)(viii)(C) and (b)(3)(ix)(C) of this section in that State, provided that the State notifies HHS of that decision in advance of the annual QHP certification application deadline, by a date to be established by HHS.

(4) * * *

(ii) * * *

(B) * * *

(*1*) In a Federally-facilitated SHOP, payment for the group's first month of coverage must be received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage begins.

(*2*) In a Federally-facilitated SHOP, when coverage is effectuated retroactively, payment for the first month's coverage and all months of the retroactive coverage must be received and processed no later than 30 days after the event that triggers the eligibility for retroactive coverage. If payment is received on or before the 20th day of a month, coverage will be effectuated upon the first day of the following month retroactive to the effective date of coverage. If payment is received after the 20th day of a month, coverage will be effectuated upon the first day of the second following month retroactive to the effective date of coverage, provided that the payment includes the premium for the intervening month.

(C) * * *

(*2*) The number of days for which coverage is being provided in the month described in paragraph (b)(4)(ii)(C)(*1*) of this section.

* * * * *

(11) * * *

(ii) * * *

(A) When the employer offers a single plan to qualified employees, the employer must use a fixed contribution methodology under which the employer contributes a fixed percentage of the plan's premium for each qualified employee and, if applicable, for each dependent of a qualified employee. The employer's contribution is calculated based on an enrollee's premium before any applicable tobacco surcharge, based on the total premium owed for the enrollee, is applied.

(B) When the employer offers a choice of plans to qualified employees, the employer may use a fixed contribution methodology or a reference plan contribution methodology. Under the fixed contribution methodology, the employer contributes a fixed percentage of the premiums for each qualified employee and, if applicable, for each dependent of a qualified employee, across all plans in which any qualified employee, and, if applicable, any dependent of a qualified employee, is enrolled. Under the reference plan contribution methodology, the employer will select a plan from among the plans offered by the employer as described in paragraphs (b)(2) and (3) of this section to serve as a reference plan on which contributions will be based, and then will define a percentage contribution toward premiums under the reference plan; the resulting contribution amounts under the reference plan will be applied toward any plan in which a qualified employee or, if applicable, any dependent of a qualified employee, is enrolled, up to the lesser of the contribution amount or the total amount of any premium for the selected plan before application of a tobacco surcharge, if applicable. The employer's contribution is calculated based on an enrollee's premium before any applicable tobacco surcharge, based on the total premium owed for the enrollee, is applied.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage. To the extent permitted by other applicable law, for plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP may permit an employer to define a different percentage contribution for full-time employees from the percentage contribution it defines for non-full-time employees, and it may permit an employer to define a different percentage contribution for dependent coverage for full-time employees from the percentage contribution it defines for dependent coverage for non-full-time employees.

(D) A Federally-facilitated SHOP may permit employers to base contributions on a calculated composite premium for employees, for adult dependents, and for dependents below age 21.

* * * * *

■ 48. Section 155.715 is amended by revising paragraph (g)(1) to read as follows:

§ 155.715 Eligibility determination process for SHOP.

* * * * *

(g) * * *

(1) Each QHP terminates the enrollment through the SHOP of the employer's enrollees enrolled in a QHP through the SHOP; and

* * * * *

■ 49. Section 155.725 is amended by revising paragraphs (c), (e), (h)(2), (i)(1) introductory text, and (j)(2)(i) to read as follows:

§ 155.725 Enrollment periods under SHOP.

* * * * *

(c) *Annual employer election period.* The SHOP must provide qualified

employers with a standard election period prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including—

(1) The method by which the qualified employer makes QHPs available to qualified employees pursuant to § 155.705(b)(2) and (3);

(2) The employer contribution towards the premium cost of coverage;

(3) The level of coverage offered to qualified employees as described in § 155.705(b)(2) and (3); and

(4) The QHP or QHPs offered to qualified employees in accordance with § 155.705.

* * * * *

(e) *Annual employee open enrollment period.* (1) The SHOP must establish a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(2) Qualified employers in a Federally-facilitated SHOP must provide qualified employees with an annual open enrollment period of at least one week.

* * * * *

(h) * * *

(2) For a group enrollment received by the Federally-facilitated SHOP from a qualified employer at the time of an initial group enrollment or renewal:

(i) Between the first and fifteenth day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(ii) Between the 16th and last day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the second following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(i) * * *

(1) If a qualified employee enrolled in a QHP through the SHOP remains eligible for enrollment through the SHOP in coverage offered by the same qualified employer, the SHOP may provide for a process under which the employee will remain in the QHP selected the previous year, unless—

* * * * *

(j) * * *

(2) * * *

(i) Experiences an event described in § 155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in § 155.420(d)(2), (4), (5), (7), (8), or (9);

* * * * *

■ 50. Section 155.735 is amended by revising paragraph (c)(2) introductory text and paragraph (d)(2) to read as follows:

§ 155.735 Termination of SHOP enrollment or coverage.

* * * * *

(c) * * *

(2) In an FF–SHOP, for premium payments other than payments for the first month of coverage—

* * * * *

(d) * * *

(2) In the FF–SHOP, termination is effective:

(i) In the case of a termination in accordance with paragraphs (d)(1)(i), (ii), (iii), and (v) of this section, termination is effective on the last day of the month in which the Federally-facilitated SHOP receives notice of the event described in paragraph (d)(1)(i), (ii), (iii), or (v) of this section.

(ii) In the case of a termination in accordance with paragraph (d)(1)(iv) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP, including for any retroactive enrollments effectuated under § 155.725(j)(5).

(iii) The FF–SHOP will send qualified employees a notice notifying them in advance of a child dependent's loss of eligibility for dependent child coverage under their plan because of age. The notice will be sent 90 days in advance of the date when the dependent enrollee would lose eligibility for dependent child coverage. The enrollee will also receive a separate termination notice when coverage is terminated, under § 155.735(g).

* * * * *

■ 51. Section 155.740 is amended by revising paragraphs (c)(2), (d)(2), and (l)(3) to read as follows:

§ 155.740 SHOP employer and employee eligibility appeals requirements.

* * * * *

(c) * * *

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 155.715(e).

(d) * * *

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 155.715(f).

* * * * *

(l) * * *

(3) Be effective as follows:

(i) If an employer is found eligible under the decision, then at the employer's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made retroactive to the effective date of coverage or enrollment through the SHOP that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(ii) For employee appeal decisions only, if an employee is found eligible under the decision, then at the employee's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made effective retroactive to the effective date of coverage or enrollment through the SHOP that the employee would have had if the employee had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(iii) If the employer or employee is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

* * * * *

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 52. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1313, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

■ 53. Section 156.50 amended by revising paragraph (c) to read as follows:

§ 156.50 Financial support.

* * * * *

(c) *Requirement for Federally-facilitated Exchange user fee.* (1) To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for Federally-facilitated Exchanges for the applicable benefit year and the monthly premium

charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.

(2) To support the functions of State-based Exchanges on the Federal platform, unless the State-based Exchange and HHS agree on an alternative mechanism to collect the funds, a participating issuer offering a plan through a State-based Exchange that elects to utilize the Federal Exchange platform for certain Exchange functions described in § 155.200 of this subchapter, as specified in a Federal platform agreement, must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the sum of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for State-based Exchanges that use the Federal platform for the applicable benefit year plus, if a written request is made by a State, any additional user fee rate that HHS will collect on behalf of the State-based Exchange, multiplied by the monthly premium charged by the issuer for each policy under the plan where enrollment is through the State-based Exchange on the Federal platform.

* * * * *

■ 54. Section 156.80 is amended by revising paragraph (d)(3)(ii) to read as follows:

§ 156.80 Single risk pool.

* * * * *

(d) * * *

(3) * * *

(ii) A health insurance issuer in the small group market (not including a merged market) may establish index rates and make the marketwide adjustments under paragraph (d)(1) of this section, and make the plan-level adjustments under paragraph (d)(2) of this section, no more frequently than quarterly. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan.

* * * * *

■ 55. Section 156.115 is amended by revising paragraph (a)(5) introductory text to read as follows:

§ 156.115 Provision of EHB.

(a) * * *

(5) With respect to habilitative services and devices—

* * * * *

■ 56. Section 156.122 is amended by adding paragraph (c)(4) to read as follows:

§ 156.122 Prescription drug benefit.

* * * * *

(c) * * *

(4) *Application of coverage appeals laws.* (i) A State may determine that a health plan in the State satisfies the requirements of this paragraph (c) if the health plan has a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are at least as stringent as the requirements of this paragraph (c) and include:

(A) An internal review;

(B) An external review;

(C) The ability to expedite the reviews; and

(D) Timeframes that are the same or shorter than the timeframes under paragraphs (c)(1)(ii) and (c)(2)(iii) of this section.

* * * * *

■ 57. Section 156.135 is amended by revising paragraph (g) to read as follows:

§ 156.135 AV calculation for determining level of coverage.

* * * * *

(g) *Updates to the AV Calculator.* HHS will update the AV Calculator annually for material changes that may include costs, plan designs, the standard population, developments in the function and operation of the AV Calculator and other actuarially relevant factors.

■ 58. Section 156.150 is amended by adding paragraphs (a)(1) and (2), (c), and (d) to read as follows:

§ 156.150 Application to stand-alone dental plans inside the Exchange.

(a) * * *

(1) For plan years beginning after 2017, for one covered child—the dollar limit applicable to a stand-alone dental plan for one covered child specified in this paragraph (a) increased by the percent increase of the consumer price index for dental services for the year 2 years prior to the applicable plan year over the consumer price index for dental services for 2016.

(2) For plan years after 2017, for two or more covered children—twice the dollar limit for one child described in paragraph (a)(1) of this section.

* * * * *

(c) *Consumer price index for dental services defined.* The consumer price index for dental services is a sub-component of the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index specific to dental services.

(d) *Increments of cost sharing increases.* Any increase in the annual dollar limits described in paragraph (a)(1) of this section that does not result in a multiple of 25 dollars will be rounded down, to the next lowest multiple of 25 dollars.

■ 59. Section 156.230 is amended by adding paragraphs (d) and (e) to read as follows:

§ 156.230 Network adequacy standards.

* * * * *

(d) *Provider transitions.* A QHP issuer in a Federally-facilitated Exchange must—

(1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

(2) In cases where a provider is terminated without cause, allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

(i) For the purposes of paragraph (d)(2) of this section, active course of treatment means:

(A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

(B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(C) The second or third trimester of pregnancy, through the postpartum period; or

(D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) Any QHP issuer decision made for a request for continuity of care under paragraph (d)(2) of this section must be subject to the health benefit plan's

internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

(e) *Out-of-network cost sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP that uses a provider network must:

(1) Notwithstanding § 156.130(c), count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or

(2) Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

■ 60. Section 156.235 is amended by revising paragraphs (a)(2)(i) and (b)(2)(i) to read as follows:

§ 156.235 Essential community providers.

(a) * * *

(2) * * *

(i) The network includes as participating practitioners at least a minimum percentage, as specified by HHS, of available essential community providers in each plan's service area. For plan years beginning prior to January 1, 2018, multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard. For plan years beginning on or after January 1, 2018, multiple contracted or employed full-time equivalent practitioners at a single location will count toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard; and

* * * * *

(b) * * *

(2) * * *

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal Poverty Line satisfies a minimum percentage, specified by HHS, of available essential community provider in the plan's service area. For plan years beginning prior to January 1, 2018, multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard. For plan years beginning on or after January 1, 2018, multiple contracted or employed full-time equivalent practitioners at a single location will count toward both the available essential community providers in the plan's service area and the satisfaction of the essential community provider participation standard; and

* * * * *

■ 61. Section 156.265 is amended by revising paragraph (b)(2)(ii) and adding paragraphs (b)(3) through (5) to read as follows:

§ 156.265 Enrollment process for qualified individuals.

* * * * *

(b) * * *

(2) * * *

(ii) Ensure the applicant's completion of an eligibility verification and enrollment application through the Exchange Internet Web site as described in § 155.405, or ensure that the eligibility application information is submitted for an eligibility determination through the Exchange-approved Web service subject to meeting the requirements in paragraph (b)(3) through (5) of this section;

(3) When an Internet Web site of an issuer is used to complete the Exchange eligibility application outlined in this section, at a minimum, the Internet Web site must:

(i) Use exactly the same eligibility application language as appears in the FFE Single Streamlined Application required in § 155.405 of this subchapter, unless HHS approves a deviation;

(ii) Ensure that all necessary information for the consumer's applicable eligibility circumstances are submitted through the Exchange-approved Web service; and

(iii) Ensure that the process used for consumers to complete the eligibility application complies with all applicable Exchange standards, including §§ 155.230 and 155.260(b) of this subchapter.

(4) An issuer must obtain HHS approval that the requirements of this section have been met prior to completing an applicant's eligibility application through the issuer's Internet Web site.

(5) HHS or its designee may periodically monitor and audit an agent, broker, or issuer to assess its compliance with the applicable requirements of this section.

* * * * *

■ 62. Section 156.270 is amended by revising paragraphs (d) introductory text and (g) to read as follows:

§ 156.270 Termination of coverage or enrollment for qualified individuals.

* * * * *

(d) *Grace period for recipients of advance payments of the premium tax credit.* A QHP issuer must provide a grace period of 3 months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit. During the grace period, the QHP issuer must:

* * * * *

(g) *Exhaustion of grace period.* If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, subject to a premium payment threshold implemented under § 155.400(g) of this subchapter, if applicable, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the effective date described in § 155.430(d)(4) of this subchapter, provided that the QHP issuer meets the notice requirement specified in paragraph (b) of this section.

* * * * *

■ 63. Section 156.285 is amended by revising paragraph (c)(5) and removing and reserving paragraph (d)(2) to read as follows:

§ 156.285 Additional standards specific to SHOP.

* * * * *

(c) * * *

(5) Send enrollment reconciliation files on at least a monthly basis, and, in a Federally-facilitated SHOP, according to a process, timeline, and file format established by the Federally-facilitated SHOP;

* * * * *

■ 64. Section 156.298 is amended by—

■ a. Revising paragraph (b)(4).

■ b. Removing paragraph (b)(5).

■ c. Redesignating paragraph (b)(6) as paragraph (b)(5).

■ d. Revising newly redesignated paragraph (b)(5).

The revisions read as follows:

§ 156.298 Meaningful difference standard for Qualified Health Plans in the Federally-facilitated Exchanges.

* * * * *

(b) * * *

(4) Plan type; or

(5) Child-only versus non Child-only plan offerings.

* * * * *

■ 65. The heading of subpart D is revised to read as follows:

Subpart D—Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform

■ 66. Section 156.350 is added to read as follows:

§ 156.350 Eligibility and enrollment standards for Qualified Health Plan issuers on State-based Exchanges on the Federal platform.

(a) In order to participate in a State-based Exchange on the Federal platform, a QHP issuer must comply with HHS regulations, and guidance pertaining to issuer eligibility and enrollment functions as if the issuer were an issuer of a QHP on a Federally-facilitated Exchange. These requirements include—

(1) Section 156.285(a)(4)(ii) regarding the premiums for plans offered on the SHOP;

(2) Section 156.285(c)(8)(iii) regarding enrollment process for SHOP; and

(3) Section 156.715 regarding compliance reviews of QHP issuers, to the extent relating directly to applicable eligibility and enrollment functions.

(b) HHS will permit issuers of QHPs in each State-based Exchange on the Federal platform to directly enroll applicants in a manner that is considered to be through the Exchange, as if the issuers were issuers of QHPs on Federally-facilitated Exchanges under § 156.1230(a), to the extent permitted by applicable State law.

(c) If the State-based Exchange on the Federal platform does not substantially enforce a requirement in paragraph (a) of this section against the issuer or plan, then HHS may do so, in accordance with the enforcement remedies in subpart I of this part, subject to the administrative review process in subpart J of this part.

■ 67. Section 156.805 is amended by revising paragraph (d) to read as follows:

§ 156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

* * * * *

(d) *Request for hearing.* (1) An issuer may appeal the assessment of a civil money penalty under this section by filing a request for hearing under an applicable administrative hearing process.

(2) If an issuer files a request for hearing under this paragraph (d), the assessment of a civil money penalty will not occur prior to the issuance of the final administrative decision in the appeal.

* * * * *

■ 68. Section 156.810 is amended by revising paragraphs (a)(12) and (13) and (e) and adding paragraphs (a)(14) and (15) to read as follows:

§ 156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) * * *

(12) The QHP issuer substantially fails to meet the requirements related to the cases forwarded to QHP issuers under subpart K of this part;

(13) The QHP issuer substantially fails to meet the requirements related to the offering of a QHP under subpart M of this part;

(14) The QHP issuer offering the QHP is the subject of a pending, ongoing, or final State regulatory or enforcement action or determination that relates to the issuer offering QHPs in the Federally-facilitated Exchanges; or

(15) HHS reasonably believes that the QHP issuer lacks the financial viability to provide coverage under its QHPs until the end of the plan year.

* * * * *

(e) *Request for hearing.* An issuer may appeal the decertification of a QHP offered by that issuer under paragraph (c) or (d) of this section by filing a request for hearing under an applicable administrative hearing process.

(1) If an issuer files a request for hearing under this paragraph (e):

(i) If the decertification is under paragraph (b)(1) of this section, the decertification will not take effect prior to the issuance of the final administrative decision in the appeal, notwithstanding the effective date specified in paragraph (b)(1) of this section.

(ii) If the decertification is under paragraph (b)(2) of this section, the decertification will be effective on the date specified in the notice of decertification, but the certification of the QHP may be reinstated immediately upon issuance of a final administrative decision that the QHP should not be decertified.

(2) [Reserved]

■ 69. Section 156.1110 is amended by revising paragraphs (a) and (b) and removing paragraph (d) to read as follows:

§ 156.1110 Establishment of patient safety standards for QHP issuers.

(a) *Patient safety standards.* A QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital, as defined in section 1861(e) of the Act:

(1) For plan years beginning before January 1, 2017, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Conditions of Participation requirements for—

(i) A quality assessment and performance improvement program as specified in 42 CFR 482.21; and

(ii) Discharge planning as specified in 42 CFR 482.43.

(2) For plan years beginning on or after January 1, 2017—

(i)(A) Utilizes a patient safety evaluation system as defined in 42 CFR 3.20; and

(B) Implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; or

(ii) Implements an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination.

(3) A QHP issuer must ensure that each of its QHPs meets the patient safety standards in accordance with this section.

(b) *Documentation.* A QHP issuer must collect:

(1) For plan years beginning before January 1, 2017, the CCN from each of its contracted hospitals with greater than 50 beds, to demonstrate that those hospitals meet patient safety standards required in paragraph (a)(1) of this section; and

(2) For plan years beginning on or after January 1, 2017, information, from each of its contracted hospitals with greater than 50 beds, to demonstrate that those hospitals meet patient safety standards required in paragraph (a)(2) of this section.

* * * * *

■ 70. Section 156.1215 is amended by revising paragraphs (b) and (c) to read as follows:

§ 156.1215 Payment and collections processes.

* * * * *

(b) *Netting of payments and charges for later years.* As part of its payment

and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal or State governments from the issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, payment of any fees for State-based Exchanges utilizing the Federal platform, and risk adjustment, reinsurance, and risk corridors payments and charges.

(c) *Determination of debt.* Any amount owed to the Federal government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, including any fees for State-based Exchanges utilizing the Federal platform, risk adjustment, reinsurance, and risk corridors, after HHS nets amounts owed by the Federal government under these programs, is a determination of a debt.

■ 71. Section 156.1220 is amended by revising paragraphs (a)(3) and (a)(4)(ii) to read as follows:

§ 156.1220 Administrative appeals.

(a) * * *

(3) *Time for filing a request for reconsideration.* The request for reconsideration must be filed in accordance with the following timeframes:

(i) For advance payments of the premium tax credit, advance payments of cost-sharing reductions, Federally-facilitated Exchange user fee charges, or State-based Exchanges utilizing the Federal platform fees, within 60 calendar days after the date of the final reconsideration notification specifying the aggregate amount of advance payments of the premium tax credit, advance payments of cost-sharing reductions, Federally-facilitated Exchange user fees, and State-based Exchanges utilizing the Federal platform fees for the applicable benefit year;

(ii) For a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within 30 calendar days of the date of the notification under § 153.310(e) of this subchapter;

(iii) For a reinsurance payment, within 30 calendar days of the date of the notification under § 153.240(b)(1)(ii) of this subchapter;

(iv) For a default risk adjustment charge, within 30 calendar days of the date of the notification of the default risk adjustment charge;

(v) For reconciliation of cost-sharing reductions, within 60 calendar days of the date of the notification of the cost-sharing reduction reconciliation payment or charge; and

(vi) For a risk corridors payment or charge, within 30 calendar days of the date of the notification under § 153.510(d) of this subchapter.

(4) * * *

(ii) Notwithstanding paragraph (a)(1) of this section, a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under § 153.710(d)(2) of this subchapter, it was so identified and remains unresolved.

* * * * *

■ 72. Section 156.1250 is revised to read as follows:

§ 156.1250 Acceptance of certain third party payments.

Issuers offering individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments for the QHPs from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):

(a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

(b) An Indian tribe, tribal organization, or urban Indian organization; and

(c) A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

■ 73. Section 156.1256 is added to read as follows:

§ 156.1256 Other notices.

As directed by the FFE, a health insurance issuer that is offering QHP coverage through an FFE or an SBE–FP must notify its enrollees of material plan or benefit display errors and the enrollees' eligibility for a special enrollment period, included in § 155.420(d)(4) of this subchapter, within 30 calendar days after being notified by the FFE that the error has been fixed, if directed to do so by the FFE.

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

■ 74. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), as amended.

■ 75. Section 158.103 is amended by revising the definitions of ''Large Employer'' and ''Small Employer'' to read as follows:

§ 158.103 Definitions.

* * * * *

Large Employer has the meaning given the term in § 144.103 of this subchapter.

* * * * *

Small Employer has the meaning given the term in § 144.103 of this subchapter.

* * * * *

Dated: February 22, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: February 23, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2016–04439 Filed 2–29–16; 4:15 pm]

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Part III

Department of Housing and Urban Development

24 CFR Parts 5, 880, 884, et al.
Streamlining Administrative Regulations for Public Housing, Housing Choice Voucher, Multifamily Housing, and Community Planning and Development Programs; Final Rule

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Parts 5, 880, 884, 886, 891, 903, 960, 966, 982, 983, 990

[Docket No. FR 5743–F–03]

RIN 2577–AC92

Streamlining Administrative Regulations for Public Housing, Housing Choice Voucher, Multifamily Housing, and Community Planning and Development Programs

AGENCY: Office of the Deputy Secretary, HUD.

ACTION: Final rule.

SUMMARY: The Department of Housing and Urban Development Appropriations Act, 2014 (2014 Appropriations Act), made several changes to the United States Housing Act of 1937 (1937 Act). Section 243 of the 2014 Appropriations Act authorized HUD to implement these changes through notice, followed by notice-and-comment rulemaking. Notices implementing the changes were published on May 19, 2014, and June 25, 2014. HUD issued a proposed rule on January 6, 2015, to codify these changes in regulation. In addition, the January 2015 rule proposed changes to streamline regulatory requirements pertaining to certain elements of the Housing Choice Voucher (HCV), Public Housing (PH), and various multifamily housing (MFH) rental assistance programs; to reduce the administrative burden on public housing agencies (PHAs) and MFH owners; and to align, where feasible, requirements across programs, including the Housing Opportunities for Persons with AIDS (HOPWA) and HOME Investment Partnerships (HOME), which are administered by HUD's Office of Community Planning and Development (CPD). HUD also issued an interim rule on September 8, 2015, implementing changes to flat rents in the Public Housing program made by the Department of Housing and Urban Development Appropriations Act, 2015 (2015 Appropriations Act).

This final rule makes changes to the regulatory text as presented in the January 2015 proposed rule, including additional changes in response to public comment as well as further consideration by HUD of changes proposed in January 2015, and finalizes the regulatory changes contained in the September 2015 interim rule.

DATES: *Effective Date:* April 7, 2016.

FOR FURTHER INFORMATION CONTACT: For questions regarding programs operated by HUD's Office of Community Planning and Development, contact Henrietta Owusu, Director, Program Policy Division, Office of Affordable Housing Programs, at 202–402–4998. For the HCV program, contact Becky Primeaux, Director, Housing Voucher Management and Operations Division, at 202–402–6050. For questions regarding the Multifamily Housing programs, contact Katherine Nzive, Director, Program Administration Office, Asset Management and Portfolio Oversight, at 202–708–3000. For the Public Housing program, contact Todd Thomas, Program Analyst, Public Housing Management and Occupancy Division, at 678–732–2056. None of the phone numbers included is toll-free. Persons with hearing or speech impairments may access these numbers through TTY by calling the toll-free Federal Relay Service at 800–877–8339. Any of the above-listed contacts may also be reached via postal mail at the following address: Department of Housing and Urban Development, 451 7th Street SW., Washington, DC 20410.

SUPPLEMENTARY INFORMATION:

I. Background

The 2014 Appropriations Act made changes to certain provisions of the 1937 Act, such as allowing for biennial physical inspections of certain assisted properties and permitting alternative inspection methods to be used in certain circumstances, codifying in statute the definition of ''extremely low-income,'' and capping utility allowances at the lesser of the unit size on the voucher or the size of the unit leased by the family. These changes were implemented by notice; [1] a proposed rule to codify the changes in regulation was published on January 6, 2015, at 80 FR 423.

In addition, HUD has solicited recommendations in recent years on how to streamline program operations to reduce costs and enhance efficiency while still maintaining HUD's core program oversight functions. The January 2015 proposed rule included programmatic changes to implement many of these suggestions. A detailed description of all proposed amendments, including technical corrections also proposed, and the reasons for the amendments can be found in the preamble to the January 6, 2015 proposed rule at 80 FR 424 to 428.

As further discussed below, portions of this final rule affect the PH program, the HCV program, the CPD programs mentioned above,[2] and the following MFH programs: [3]

- Project-Based Section 8 (New Construction, State Agency-Financed, Substantial Rehabilitation, Rural Housing Services, Loan Management Set-Aside, and Property Disposition Set-Aside).
- Section 8 Moderate Rehabilitation.
- Rent Supplement Program.
- Section 202 Supportive Housing for the Elderly (including Project Assistance Contract and Project Rental Assistance Contract (PRAC)).
- Section 811 Supportive Housing for Persons with Disabilities (including PRAC and Project Rental Assistance).
- Section 236 Interest Reduction Payments Program.
- Rental Assistance Payment (RAP) Program.
- Sections 221(d)(3) and (d)(5)—FHA Insurance Programs for New Construction or Substantially Rehabilitated Multifamily Rental Housing.

Some of the new flexibilities will require a PHA to make changes to the PHA's Admissions and Continued Occupancy Policy, Administrative Plan, or PHA plan in order for the PHA to adopt the new authorities. HUD encourages all PHAs adopting such flexibilities to make all required amendments as expeditiously as possible.

The 2015 Appropriations Act amended section 3 of the 1937 Act to allow for additional flexibility to the requirement that the flat rental amount be set at no less than 80 percent of the applicable FMR, as established under 8(c) of the 1937 Act. HUD may allow a PHA to establish a flat rent based on an FMR that is based on an area geographically smaller than would otherwise be used, if HUD determines that the resulting FMR more accurately reflects local market conditions. In addition, a PHA may apply to HUD for an exception allowing a flat rental amount that is lower than the amount otherwise determined under the two

[1] Notice PIH 2014–12, published May 19, 2014, implemented the changes to flat rents; 79 FR 35940, ''HUD Implementation of Fiscal Year 2014 Appropriations Provisions on Public Housing Agency Consortia, Biennial Inspections, Extremely Low-Income Definition, and Utility Allowances'' (June 25, 2014), implemented all other changes.

[2] The only provision in this final regulation that applies directly to the CPD programs is the earned income disregard. Other provisions that apply do so indirectly, either because of references in program-specific regulations or due to particular eligible activities that follow the requirements of the Housing Choice Voucher program. The parenthetical statements at the end of each subpart of section II.A, exclude mention of CPD programs.

[3] In the January 6, 2015 proposed rule, HUD inadvertently included reference to FHA's Section 235 Homeownership program, but as provided in a final rule published on April 3, 2015, this program is no longer active and the regulations were removed by the April 3, 2015 final rule. See *http://www.gpo.gov/fdsys/pkg/FR-2015-04-03/pdf/2015-07597.pdf.*

allowable FMRs, if HUD determines that the two FMRs do not reflect the market value of the property and the lower flat rental amount is based on a market analysis of the applicable market. In either case, the alternative flat rent must not create a disincentive for families seeking to become economically self-sufficient to continue to reside in public housing.

On September 8, 2015, at 80 FR 53709, HUD published an interim rule to amend HUD's regulations implementing the 2014 Appropriations Act language on flat rents to allow PHAs the opportunity to take advantage of the 2015 Appropriations Act authority that provides PHAs with more flexibility in setting flat rents. HUD advised that the interim rule superseded the portion of the January 2015 proposed rule year that addressed the issue of setting flat rents in public housing. Although HUD issued the September 2015 rule as an interim rule for effect, HUD sought public comment for a period of 60 days. By the end of the comment period on November 9, 2015, HUD received seven comments.

II. Changes Made at the Final Rule Stage

In response to public comment and as a result of further consideration of certain issues by HUD, this final rule makes the following revisions to the January 2015 proposed rule. With respect to changes made in response to public comment, the issues raised by the commenter and HUD's basis for responding to the comments are addressed in Section IV of this preamble. No changes are made to the September 2015 interim rule on flat rents.

A. HCV, MFH, and PH Program Regulations

1. Verification of Social Security Numbers (§ 5.216)

The use of the phrase ''date of admission'' appeared twice in the proposed rule, first to identify the endpoint of the 6-month period during which a family member under the age of 6 years who lacks a Social Security Number (SSN) may have been added to an applicant family, and then again to identify the starting point for the 90-day period allotted to such a family to obtain an SSN for the newly added child. Commenters stated that, in the HCV program, the ''date of admission'' is typically the date of lease-up (*i.e.,* the effective date of the Housing Assistance Payment (HAP) contract). Prior to lease-up, however, a PHA may have expended considerable time and resources pulling a family from the waiting list, obtaining the necessary verifications, procuring a Housing Quality Standards (HQS) inspection, and performing a rent reasonableness determination. Lease-up could ultimately occur more than 6 months from the date the child was added the household, which would result in the household being ineligible for admission to the program. To obviate such a scenario, HUD has, in this final rule, adopted two separate ''dates of admission'' for the HCV program for purposes of this provision: The date of voucher issuance and the date of lease-up. Specifically, the endpoint of the 6-month period during which a family member under the age of 6 years may be added to the household is the date of voucher issuance; the 90-day clock does not start ticking until the date of lease-up. (This provision applies to the HCV/Project-Based Voucher (PBV), Rent Supplement, Section 8, Sections 221(d)(3) and (d)(5), Section 236, 202/811, and PH programs.)

2. Definition of Extremely Low-Income Families (§§ 5.603, 903.7, 960.102)

The definition of an extremely low-income family in the final rule is revised to include the phrase ''a very low-income family,'' which is included in the statutory definition and was inadvertently omitted from the proposed rule. (This provision applies to the HCV/PBV, Section 8, and PH programs. It does not apply to the Rent Supplement, Section 235, Section 236, Sections 221(d)(3) or (d)(5) programs.)

3. Use of Actual Past Income (§ 5.609)

For the reasons presented below, HUD has decided against pursuing the regulatory changes included in the proposed rule.

4. Exclusion of Mandatory Education Fees From Income (§ 5.609(b)(9))

There is no change from the proposed rule. The final rule includes fees within the definition of tuition. (This provision applies to the HCV/PBV, Section 8, and PH programs. It does not apply to the Rent Supplement, Section 236, Sections 221(d)(3) or (d)(5) programs.)

5. Streamlined Annual Reexamination for Fixed Incomes (§§ 5.657, 880.603, 884.218, 886.124, 886.324, 891.410, 891.610, 891.750, 960.257, 982.516)

Based on comments submitted, this provision was revised substantially from the proposed rule, which would have provided for a streamlined annual reexamination of family income for any family whose income consists solely of fixed sources. The final rule provides for a streamlined income determination for any fixed source of income, even if a person or a family with a fixed source of income also has a non-fixed source of income. The final rule requires that, upon admission to a program, third-party verification of all income amounts must be obtained for all family members, and a full reexamination and redetermination of income must likewise be performed every 3 years. In the interim, a streamlined income determination may be performed for a family member with a fixed source of income by applying to a previously determined or verified source of income a cost of living adjustment (COLA) or interest rate adjustment specific to each source of fixed income. The COLA or current interest rate applicable to each source of fixed income must be obtained either from a public source or from tenant-provided, third-party generated documentation. In the absence of such verification for any source of fixed income, third-party verification of income amounts must be obtained.

While the final rule amends more regulatory provisions than the proposed rule, the policy has not changed. Instead, there are cross-references to 24 CFR 5.657(d), pertaining to the reexamination of family income and composition in Section 8 project-based assistance programs, inserted in various MFH regulations herein to avoid confusion and ensure the policy is included in the regulations for all programs this provision is intended to affect. (This provision applies to the HCV/PBV, Section 8 (other than Moderate Rehabilitation), 202/811, and PH programs. It does not apply to the Rent Supplement, Section 236, Sections 221(d)(3) or (d)(5) programs.)

HUD recognizes that prior to the issuance of this final rule, the Fixing America's Surface Transportation Act, or FAST Act, was signed into law.[4] Section 78001 of that Act modified the 1937 Act to allow PHAs and owners to undergo full income recertification for families with 90 percent or more of their income from fixed-income sources every three years instead of annually. HUD believes that while the FAST Act provisions and the provisions contained in this rule are very similar, they offer different benefits; therefore, HUD is retaining the flexibilities in this final rule and will issue implementation regulations for the FAST Act separately.

6. Earned Income Disregard (EID) (§§ 5.617, 960.255)

The proposed rule included a requirement that families maintain continual employment in order to

[4] Public Law 114–94, signed December 4, 2015.

obtain EID benefits over a straight 24-month period, and it allowed families who received the full EID benefit and then subsequently requalified for the benefit to obtain it again (*i.e.,* the proposed rule eliminated the maximum lifetime disallowance). The proposed rule also included a carve-out for the HOPWA program, which retained the provision unchanged.

In the final rule, all HUD programs to which the EID applies (including the HOPWA program) are aligned, the lifetime disallowance is retained, and the requirement to maintain continual employment is dropped. Ultimately, the only change to the existing regulation adopted in the final rule is that the benefit now applies for a straight 24-month period, with a clear start date and end date, irrespective of whether a family maintains continual employment during the 24-month period. PHAs and grantees are no longer obliged to track employment starts and stops, but only the start date, the 12-month date (on which the amount of the disregard may change from 100 percent to not less than 50 percent of earned income), and the 24-month (end) date.

For families enrolled and participating in EID prior to the effective date of this regulation, the previous requirements will continue to apply. (This provision applies to the HCV/PBV, HOME, HOPWA, and PH programs. It does not apply to the MFH programs.) HUD intends to publish a notice describing the changes and the administrative requirements prospectively. For current recipients of the EID, HUD will reiterate that regulations in effect immediately prior to this rule will continue to apply until the benefit period expires for these families.

B. HCV and PH Program Regulations

1. Family Declaration of Assets Under $5,000 (§§ 960.259, 982.516)

Upon further consideration and in light of comments received, HUD made a modest change to this provision from the proposed to the final rule. The proposed rule would have authorized a PHA to rely on a family's declaration starting with the first reexamination and going forward indefinitely. In the final rule, a PHA must obtain third-party documentation of assets every 3 years. The Office of Multifamily Housing Programs in HUD's Office of Housing noted support for expansion of this provision to its rental assistance programs and is issuing an interim final rule to do just that.

2. Utility Reimbursements (§§ 960.253, 982.514)

The proposed rule provides a PHA with the option of making utility reimbursement payments ''quarterly,'' for reimbursements totaling $20 or less per quarter. For the final rule, this provision is modified somewhat. The amount is raised to $45 or less per quarter. If the PHA opts to make the payments on a quarterly basis, the PHA must institute a hardship policy for the tenants if such payments would create a financial hardship for them. Based on a request for clarification, this provision was modified slightly for this final rule to make clear that reimbursements must occur no less frequently than once every calendar-year quarter. Additionally, HUD is issuing an interim final rule to expand this provision to MFH programs.

C. PH Program Regulations

1. Public Housing Rents for Mixed Families (§ 5.520(d))

There is no change from the proposed rule. The final rule requires PHAs to use the established flat rent applicable to the unit to calculate rents for mixed families. The final rule also requires that a mixed family's payment be equivalent to their total tenant payment (TTP) when their TTP exceeds the flat rent.

2. Tenant Self-Certification for Community Service Requirements (§§ 960.605, 960.607)

Just as in the proposed rule, the final rule permits PHAs to accept a tenant's signed self-certification of compliance with the community service requirement. However, to better ensure compliance with the community service requirement, HUD is requiring PHAs to review a sample of self-certifications and validate their accuracy with the third-party verification procedures currently in place. The PHA will also need to notify tenants that any self-certification may be subject to such validation.

3. Public Housing Grievance Procedures (§§ 966.4 and 966.52 Through 966.57)

Upon further consideration and in light of comments received, HUD has decided against pursuing regulatory changes pertaining to the requirement that a PHA prepare a summary of any informal settlement. HUD has also decided against pursuing changes related to the ability of either party to a grievance to request, at their own expense, that a transcript of a grievance hearing be prepared. Further, in light of comments received, HUD has provided a clarification regarding the Limited English Proficiency requirements related to grievance procedures.

This final rule maintains the elimination of the requirement that PHAs consult resident organizations before appointing a hearing officer. However, in light of comments that residents should have input into the selection process, HUD is requiring that PHAs include their policies regarding the selection process in the tenant lease form, which is subject to a 30-day comment period. Finally, the final rule also maintains the elimination of the requirement that PHAs retain a redacted copy of each hearing decision to be made available to prospective complainants, and in the place of that requirement, requires PHAs to maintain a log of hearing officer decisions as described through HUD guidance.

4. Limited Vacancies (§ 990.150)

There is no change from the proposed rule. The final rule clarifies that the number of vacant units eligible for operating subsidy must be not more than 3 percent of the total units, on a project-by-project basis.

D. HCV Program Regulations

1. Start of Assisted Tenancy (§ 982.309)

For the reasons presented below, HUD has decided against pursuing the regulatory changes included in the proposed rule.

2. Biennial Inspections and the Use of Alternative Inspection Methods (§§ 982.405, 982.406, 983.103)

Upon further consideration, HUD made a change to this provision to clarify that if an alternative inspection method employs sampling, the PHA may rely upon that method only if HCV units are included in the population of units forming the basis of the sample. In addition, in response to public comments, HUD is requiring PHAs wishing to rely upon inspection methods other than those conducted pursuant to the Low-Income Housing Tax Credit (LIHTC) or HOME programs, or inspections performed by HUD, to submit to HUD the protocol for the inspection method they wish to use along with the PHA's analysis showing that the desired protocol meets or exceeds HQS. A PHA must submit these materials to HUD for approval and may not rely upon such alternative inspection methods until such approval has been granted.

3. Housing Quality Standards (HQS) Reinspection Fees (§ 982.405)

The Department made modest changes to this provision based on comments expressing concern about the

broad nature of this authority and requests for clarity about the treatment of fees. The proposed rule would have authorized a PHA to charge a reasonable fee if a cited deficiency remained upon reinspection. The final rule states that the fee may be charged only if an owner stated that a deficiency had been fixed and the deficiency is found during reinspection to persist or if a reinspection conducted after the expiration of the timeframe for repairs reveals that the deficiency persists. With respect to the fee, the final rule makes clear that any fees collected may be used only for activities related to the provision of tenant-based assistance.

4. Exception Payment Standards for Providing Reasonable Accommodations (§§ 982.503, 982.505)

There is no change from the proposed rule. The final rule allows a PHA to approve a payment standard of not more than 120 percent of the FMR without HUD approval if required as a reasonable accommodation for a family that includes a person with a disability.

5. Family Income and Composition: Regular and Interim Examinations (§ 982.516(c)–(e))

There is no change from the proposed rule. The final rule eliminates the requirement that a voucher agency conduct a reexamination of income whenever a new family member is added, aligning the voucher and PH regulations.

6. Utility Payment Schedules (§ 982.517)

For the reasons presented below, HUD has decided against pursuing the regulatory changes included in the proposed rule that would have authorized a PHA to define ''unit type'' as simply ''attached'' or ''detached.''

III. Discussion of Public Comments and HUD's Responses

The public comment period on the proposed rule closed on March 9, 2015, and 92 public comments were received in response to HUD's January 6, 2015, proposed rule. Comments were submitted by individual members of the public, Fair Housing advocacy groups, housing associations, and PHAs. The following presents the significant issues and questions related to the proposed rule raised by the commenters, and HUD's responses to these issues and questions.

A. CPD, HCV, MFH, and PH Program Regulations

1. Verification of Social Security Numbers (§ 5.216)

Issue: Proposal Expansion. Commenters had several suggestions for HUD to expand the proposed relief, including allowing relief if there is a newly added family member over the age of six. Others suggested that HUD simply establish a maximum time period during which a family may receive a subsidy without providing a missing SSN instead of allowing for two extension periods or that HUD should allow families to self-certify as to having obtained SSNs. Commenters also stated that the waiver should be allowed only if any enforcement action is consistent with the Administrative and Continued Occupancy Policy (ACOP) and/or the Administrative Plan and/or Tenant Selection Plan (TSP).

HUD Response: Existing regulations permit a participant household to add a new household member under the age of 6 years, even if that household member lacks an SSN at the time of admission. The participant household then has 90 days to obtain and provide documentation necessary to verify the SSN of the new household member; the processing entity may grant the household an additional 90-day extension. HUD's intent in proposing changes to the regulations governing applicants is to align the requirements for applicants with those that govern participants, including with respect to enforcement. The changes proposed above either go beyond the current requirements for participant households or vary from those requirements. As such, they are contrary to HUD's intent, and HUD declines to adopt them.

Issue: Expansion to Homeless Programs. Commenters asked HUD to expand the proposal by providing waivers to allow PHAs to house homeless individuals who are unable to provide documentation of their SSN by giving the families 90 days to provide the information.

HUD Response: HUD agrees that adopting similar flexibility with respect to homeless individuals who lack SSNs would facilitate HUD's efforts to serve homeless families. However, HUD is unable to adopt this recommended change at this time, because it is beyond the scope of this rulemaking.

Issue: Timing of Waiver. Commenters asked HUD to use the date of voucher issuance instead of the date of admission, as the date of admission usually means the date of lease-up and does not account for time for finding a unit and inspections.

HUD Response: HUD agrees with this comment and has adopted it in this final rule.

Issue: Objections. Some commenters objected to the proposal, stating that it would actually increase burden on PHAs. Others asked HUD to modify its systems to properly accept a delayed certification when there is a new child in the family or when a foster agency refuses to provide the SSN. Commenters also asked HUD to allow the use of other forms of identification, such as Individual Taxpayer Identification Numbers.

HUD Response: Several of the comments provided pertain only indirectly to the changes proposed by HUD and are therefore beyond the scope of this rulemaking. With respect to the assertion that this change may result in additional tracking and monitoring, HUD notes that, for processing entities that typically request waivers in order to house such families, the change reduces burden. In addition, the change creates benefits that offset any modest burden. Specifically, they eliminate a barrier that could otherwise prevent families from being housed, requiring no greater monitoring and tracking than is performed for participant households.

2. Definition of Extremely Low-Income (ELI) Families (§§ 5.603, 903.7, 960.102)

Issue: Low-Income Families. Commenters stated that the proposed change should not exclude households from meeting ELI eligibility who are between 30 percent and 50 percent of area median income (AMI).

HUD Response: HUD agrees with the comment and has added ''very low-income'' language to the final rule.

Issue: Requested Changes. Commenters stated that because the new definition of ELI has delayed the release of income limits, the proposal should not be finalized. Similarly, it was suggested that HUD remove income targeting completely.

HUD Response: The final rule codifies the definition of ELI in HUD's 2014 Appropriations Act. The FY 2014 Appropriations Act defines ''extremely low-income family'' to mean a very low-income family whose income does not exceed the higher of 30 percent of AMI or the poverty level. It would be contrary to the statutory change to delay in proceeding with issuance of this final rule.

Income targeting is a statutory requirement of section 16 of the 1937 Act and cannot be removed through rulemaking without statutory authority.

3. Use of Actual Past Income (§ 5.609)

Issue: Objections to the Proposed Change. Many commenters objected to the proposal's requirement that a PHA use one definition of annual income (either actual past income or projected income) for all families in a program. Also, many commenters objected to the prohibition against using both the past income provision and the provision authorizing a streamlined annual reexamination for fixed-income families. Commenters stated that these restrictions limit PHA discretion and therefore fail to provide administrative savings to PHAs.

Additionally, commenters stated that the provision did nothing to alleviate the burden associated with performing interim income reexaminations. The commenters stated that many families experience fluctuations in income over the course of a year, and that each time this happens, a housing provider must calculate income based on projected income, rather than past income. The commenters stated that furthermore, the proposal required housing providers that adopted a definition based on actual past income to calculate expenses for such things as child care and medical care during the same 12-month period, and it is difficult to have the same timeframes for all sources of income.

Other commenters stated that using past income was not an accurate way to set rent.

HUD Response: HUD agrees that the proposal provided minimal, if any, streamlining benefit, and required impractical actions on the part of housing providers in using the same time frames for income and deductions. Given the concerns raised about the proposal, HUD has decided not to adopt the use of actual past income in the final rule.

4. Exclusion of Mandatory Education Fees From Income (§ 5.609(b)(9))

Issue: Requests for Clarification. Some commenters supported the change, but expressed doubt that this provided streamlining relief and perhaps, instead, added to a PHA's burden, particularly in determining the amount of fees charged and then verifying those fees. Others asked for additional guidance on what fees would fall under this new policy.

HUD Response: HUD notes that this provision is included in the rule, not as administrative relief, but to codify in regulation language included in recent appropriations acts that has excluded from income those amounts needed to pay mandatory student fees.[5] Additional guidance from HUD regarding what constitutes such fees is forthcoming in the form of a notice that relies on the Department of Education definitions of tuition and fees. For example, a mandatory education fee would include student service fees. That same notice will provide guidance on how to verify fee information. (Note: Such fees are already excluded for purposes of the PH program, pursuant to § 5.609(b)(9).)

5. Streamlined Annual Reexamination for Fixed Incomes (§§ 5.657, 960.257, 982.516)

Issue: Clarifications and Minor Changes. Commenters supported streamlining reexaminations for families with fixed income, but asked that HUD make some small changes. In addition to the many requests that HUD permit both fixed-income streamlining and the use of actual past income, commenters asked that HUD allow for streamlined reexaminations even when the family does not have all of its income from fixed-income sources or when some family members have a variable income and others have a fixed income. Commenters also asked that either the regulatory definition of ''fixed'' income be made more flexible or HUD grant PHAs flexibility to establish their own definition.

HUD Response: As explained above, HUD has dropped the provision that would have authorized PHAs and owners to define annual income as ''actual past income.'' At the same time, in response to comments, HUD has revised this streamlined annual reexamination measure to provide PHAs and owners with the option of conducting a streamlined income redetermination for any fixed-income *source,* irrespective of whether an individual or a family also has a non-fixed source of income. This means that the regulation no longer requires a family to have 100 percent of its income from fixed sources, which resolves a number of the concerns expressed by commenters. The final rule also adopts an expanded list of fixed sources of income. With respect to income from annuities or other retirement benefit programs, insurance policies, disability or death benefits, or other similar types of periodic receipts, if a family member receives income from any of these sources and the income consists solely of periodic payments at reasonably predictable levels, then the income source may be considered to be ''fixed.'' HUD believes that these changes respond to a number of the comments received and will provide substantial relief to PHAs and owners.

Issue: Objections and Significant Changes. Some commenters stated that the proposal did not provide any streamlining benefit, and, to fully streamline, HUD should eliminate or modify the medical expense through methods like a standard deduction or self-certification of medical expenses. Commenters expressed concern that allowing streamlined recertification for fixed income families would allow such families to overlook sources of income. Some stated that HUD should still require annual income verifications, because some families would have some members with fixed income and others with variable income.

HUD Response: While HUD is amenable to adopting several of the suggestions made by commenters, HUD will not eliminate certain requirements, such as the requirement to verify medical expenses and otherwise calculate adjustments to annual income for fixed-income families. For *ongoing* medical expenses, PHAs and owners already have the option to determine anticipated expenses by calculating expenses paid by the family in the 12 months preceding recertification. For *past one-time, nonrecurring medical expenses* that have been paid in full, PHAs and owners already have the option of including these expenses at an initial, interim, or annual recertification; if such an expense has not been paid in full but is instead being paid subject to a payment plan, then the expense would be counted as anticipated either at the time it occurs, through an interim recertification, or at an upcoming annual recertification. Further, HUD will not adopt the use of self-certification of medical expenses and other deductions, due to the risk of improper payment. Along the same lines, the final rule makes clear that a full examination of family income must be conducted upon admission to a program. Also, for PHAs and owners that choose to adopt the streamlined income redetermination, a full examination of family income must be performed at least every 3 years.

6. Earned Income Disregard (§§ 5.617, 960.255)

Issue: Definition of ''continually employed'' and effect on employment. Several commenters requested that HUD modify the proposal by clarifying the requirement that the family remain continually employed.

[5] See section 213 of the Transportation, Housing and Urban Development, and Related Agencies Appropriations Act, 2015 (Pub. L. 113–235, approved Dec. 16, 2014).

In contrast to these commenters, other commenters suggested that this change should not be made, because residents eligible for EID would not be able to be continually employed for 24 months. Others objected to allowing residents to re-qualify for EID, either because it would create an additional burden on PHAs or because it could create an incentive for individuals to leave jobs when the EID expires. Some commenters expressed concern that a family losing the EID during the 24-month period would be able to qualify for a new EID period immediately, allowing for an infinite time frame to receive the EID. Commenters also suggested that HUD allow PHAs the option to allow the EID time clock to run during periods of unemployment but disregard any unemployment benefits an individual receives.

HUD Response: HUD has determined to drop the continuous employment requirement from this rulemaking. For all HUD programs that require an EID, HUD is retaining the ability of these residents to start and stop employment and still retain the benefit of the EID. However, these residents may only receive the benefit for up to 24 consecutive months from the date of initial increase in annual income. If an individual becomes eligible to receive the EID, the 24-month period will not stop if the circumstance that triggered the EID ceases; however, if the individual experiences an event that would again provide an EID benefit during the 24-month period, then the individual will be provided the rent incentive. This change eliminates the burdensome process of tracking EID starts and stops over a 48-month time period, but still provides some flexibility to tenants to receive the EID if they again obtain employment.

HUD will retain the one-time EID eligibility. Specifically, after the expiration of the 24-month period, individuals will be ineligible to receive subsequent EID benefits. HUD believes that these changes maintain the balance that HUD seeks to incentivize employment among residents while reducing the burden of administering the benefit.

Issue: Exclusion in the second 12 months. Commenters asked that HUD make the income exclusion 100 percent for the first year and 50 percent for the second 12 months.

HUD Response: HUD disagrees with this suggestion. The statutory language at section 3(d) of the 1937 Act requires PHAs to disregard 100 percent of any increase in income for the first 12 months. However, for the second 12 months, PHAs must disregard not less than 50 percent of any increase in income. PHAs have discretion during the second 12-month period to disregard more than 50 percent of any increase in income. Therefore, HUD will not adopt this suggested change.

Issue: Limiting the availability of EID. Commenters suggested that HUD align the EID effective date with a family's annual reexamination date. Others suggested that HUD should allow for income to be calculated using actual past earned income for everyone in lieu of EID, or that EID should be available only for individuals with disabilities. Commenters also suggested that HUD should allow PHAs to implement EID on their own reporting cycle.

HUD Response: HUD's intent in this rulemaking, with respect to EID, is to streamline the EID tracking process by reducing the time during which a program participant may be eligible to receive the benefit of the EID. HUD believes the changes in this rulemaking also more closely align to the statute that governs the EID. The changes suggested above are inconsistent either with the statute or with HUD's intent in this rulemaking. As a result, HUD will not adopt the suggested changes.

Issue: Additional guidance. HUD was asked for specific guidance for families that have already started EID under the previous regulations.

HUD Response: HUD agrees with this comment and has revised the final regulation to make clear that the previous regulations apply to such families.

Issue: HOPWA carve-out. Some commenters stated that allowing HOPWA to have an EID policy different from other programs with tenant populations that have disabilities is unfair to the tenants in those non-HOPWA programs.

HUD Response: HUD agrees with this recommendation and has eliminated the HOPWA program carve-out in this final rule. The final rule applies the EID uniformly to all families eligible for the benefit.

Issue: Elimination of EID. Some commenters suggested HUD should eliminate EID entirely, either because it clashes with PH's minimum rent requirement or because the family self-sufficiency program is better. Others stated that the EID should not be extended to the Shelter Plus Care and Moderate Rehabilitation/Single-Room Occupancy (SRO) programs. Some suggested that the EID time period should be limited to only three months to discourage individuals from quitting jobs at the expiration of the EID time period to avoid rent increases or that the EID time period should be expanded to 48 months to allow for more gradual rent increases.

HUD Response: As noted in response to an earlier comment, HUD's intent in this rulemaking, with respect to EID, is to streamline the EID tracking process by reducing the time during which a program participant may be eligible to receive the benefit of the EID. HUD believes the changes in this rulemaking more closely align to the statute that governs the EID. The changes suggested above are inconsistent either with the statute or with HUD's intent in this rulemaking. As a result, HUD will not adopt the suggested changes.

B. HCV and PH Program Regulations

1. Family Declaration of Assets Under $5,000 (§§ 960.259, 982.516)

Issue: Increasing Threshold. Many commenters asked that HUD increase the maximum amount of assets that can be self-certified to $10,000.

HUD Response: The final rule has not adopted this suggestion. The $5,000 amount is consistent with other policies. Existing regulations require housing providers to calculate the imputed income for assets over $5,000. Also, the Internal Revenue Service permits housing credit agencies and owners to accept a certification from families of assets under $5,000. Commenters stated that there are few residents with assets greater than $5,000.

Issue: Expansion to Admission. Some commenters asked that HUD modify the proposal to allow families to use self-certification at both admission and reexamination.

HUD Response: The final rule clarifies in the preamble that this provision applies to families at reexamination. At admission, all assets of a family will be verified as is the current practice. Also, the final rule requires a PHA to obtain third-party documentation of all family assets every three years.

Issue: Method of Certification. Commenters asked that HUD allow families to certify to total assets instead of requiring declaration of each separate asset.

HUD Response: A family's declaration of total assets may be included on a single form with each asset listed. HUD will issue further guidance about this provision of the final rule.

Issue: Expansion to Multifamily. Commenters asked that HUD allow this provision to apply to multifamily housing as well.

HUD Response: The Office of Multifamily Housing Programs, which operates various rental assistance programs, is issuing an interim final rule to accomplish this expansion.

Issue: Larger Changes to the Proposal. Some commenters asked that HUD eliminate the consideration of assets when determining income, as income from assets usually has little, if any, effect on the amount of rent paid by a family. Other commenters state that self-certification does not actually reduce burden on PHAs and may actually increase work for PHA staff.

HUD Response: Totally eliminating consideration of assets when determining income is outside the scope of this rulemaking. HUD will keep the suggestion in mind as it examines other opportunities to streamline program requirements.

Additionally, this provision is optional for PHAs. A PHA may continue to verify such assets at both admission and annual reexaminations.

2. Utility Reimbursements (§§ 960.253, 982.514)

Issue: Optional Nature of Provision. Commenters asked that HUD make this policy optional or allow PHAs to determine the frequency with which they make utility reimbursement payments. For example, some commenters requested that HUD permit annual reimbursements.

HUD Response: The changes in this rulemaking are optional, and PHAs that do not believe this provision is beneficial to their program administration may continue to provide utility reimbursements monthly. Nothing in this rulemaking permits a PHA not to provide a utility reimbursement if such a reimbursement is due. Nor does the rulemaking offer PHAs the option of making such payments less frequently than quarterly.

Issue: Frequency of Payments. Commenters asked whether the quarterly reimbursement period would be based on the calendar year or when the family moves in. Others asked for clarification on whether the payments are reimbursements or future payments.

HUD Response: The final rule has been modified to clarify that the quarterly periods are to be based on the calendar year, not the move-in date. However, HUD is not amending other policies governing when utility reimbursements are sent.

Issue: Hardship Exemption. Commenters stated that HUD should not allow any hardship exemption.

HUD Response: While the proposed rule did not contain a hardship exemption, HUD has decided for some families, waiting for a quarterly reimbursement amount may be untenable. Therefore, the final rule now requires that if PHAs make quarterly reimbursements, the PHA must have a hardship policy in place for tenants.

Issue: Quarterly Reimbursement Threshold Amount. Commenters requested that HUD increase to $50 the maximum amount of reimbursements that may be sent quarterly.

HUD Response: HUD agrees that raising the threshold for quarterly reimbursements will increase the number of families under this provision and expand the streamlining efforts. While not raising the amount to $50 per quarter, HUD has raised the threshold to $45 per quarter ($15 per month). Any burden placed on families due to this higher amount is now offset by the requirement that PHAs opting to issue quarterly utility reimbursements must include a hardship exemption policy if the quarterly payments impose a financial hardship on families.

Issue: Alternative Reimbursement Methods. Commenters asked that HUD support options other than checks for making utility reimbursement payments.

Some commenters suggested that quarterly reimbursements would not help PHAs that use automatic deposits onto a debit card.

HUD Response: HUD supports the use of alternative utility reimbursement methods, including debit cards. PHAs that choose to use such alternative methods should ensure that such reimbursement methods do not generate fees that must be paid by the tenant.

The use of quarterly reimbursement may benefit PHAs that use automatic deposits. If it does not, then HUD expects that such PHAs will not exercise this option.

Issue: Elimination of Low Reimbursement Amounts. Commenters asked that HUD eliminate utility reimbursements that are less than $10 per month or eliminate reimbursements entirely.

HUD Response: HUD does not agree that utility reimbursements for amounts less than $10 per month should be eliminated. The elimination of such reimbursements would violate sections 3 and 8 of the 1937 Act (42 U.S.C. 1437a and 1437f), which require that families pay no more than 30 percent of their annual gross income in rent for their assisted housing. HUD has determined that such rental payments are for housing and reasonable utilities costs. Therefore, eliminating a utility reimbursement of any amount would result in some program participants paying more than the maximum amount of rent that the family should pay. HUD will not adopt the suggested change.

Issue: Setting Rents by Income Bands. Commenters stated that the reimbursement burden would be completely eliminated if rents were solely determined by income bands.

HUD Response: HUD does not have the statutory authority to permit the use of rents based on income bands in the PH or HCV programs. Therefore, HUD will not adopt this suggestion.

Issue: Direct Payments. Commenters stated that owners should be able to submit utility payments directly to utility providers.

HUD Response: This rulemaking does not eliminate the option available to PHAs to make direct payments to utility providers in lieu of making utility reimbursement payments to tenants.

Issue: Prorated Reimbursements. Commenters stated that owners should be given the option to prorate the utility allowance payment based on any projected move out date; if a payment has already been disbursed when a tenant moves out, the owner should be allowed to offset the difference by using the security deposit, charging the resident for the difference, or adjusting the voucher payment amount.

HUD Response: This rulemaking requires PHAs to make a prorated utility reimbursement payment in the case of a family that moves out in advance of the next scheduled quarterly reimbursement. Likewise, if a family leaves the program with an outstanding credit from the PHA for a utility reimbursement, the PHA must reconcile the credit with the family prior to the expiration of the lease, in the case of PH, or when the HAP contract terminates or shortly thereafter, in the case of the HCV program.

C. PH Program Regulations

1. Public Housing Rents for Mixed Families (§ 5.520(d))

The comments received on this proposal were all positive and did not urge any changes. Therefore HUD is adopting the proposal, unchanged in the final rulemaking.

2. Tenant Self-Certification for Community Service and Self-Sufficiency Requirement (§§ 960.605, 960.607)

Issue: Review of Certifications. Several commenters stated that HUD should not require PHAs to obtain third-party verification when reviewing the self-certifications or should limit the times when a PHA should follow up with a third party in the review of certifications.

HUD Response: HUD agrees that it would be unnecessarily burdensome on PHAs to obtain additional third-party verification when reviewing each self-

certification. HUD is not, therefore, mandating such a process when reviewing tenant self-certifications. PHAs must, however, review the self-certifications to ensure that they are complete and provide sufficient information in order to follow up as necessary. Further, HUD strongly encourages PHAs to investigate community service compliance when there are questions of accuracy. Finally, in a change from the proposed rule, HUD is requiring PHAs to validate a sample of self-certifications and notify residents that their self-certifications may be subject to such validation in order to ensure that residents remain compliant with the community service and self-sufficiency requirement (CSSR).

Issue: Objections to Self-Certification. Several commenters objected to the proposal to allow self-certification, stating that it would reduce compliance with the CSSR.

HUD Response: While HUD understands the concerns that some residents may attempt to submit fraudulent self-certifications, the changes permit, but do not require, PHAs to accept a tenant self-certification of compliance with the CSSR in lieu of obtaining independent third-party verification. PHAs that are concerned about the potential for fraudulent self-certifications may continue to require third-party verification of compliance for each eligible resident.

Issue: Elimination of Community Service Requirement. Several commenters suggested that it would be better if HUD eliminated the community service requirement for PH entirely.

HUD Response: The CSSR is mandated by section 12(c) of the 1937 Act (42 U.S.C. 1437j(c)). HUD is therefore unable to eliminate the CSSR.

3. Public Housing Grievance Procedures (§§ 966.4 and 966.52 Through 966.57)

Issue: Alignment. Commenters suggested that all grievance procedures should be aligned across PH, Section 8, and MFH programs. This would allow for only one administrative hearing for any action. Other commenters suggested applying the revised definition of ''hearing officer'' to the HCV program, as well.

HUD Response: In general, this streamlining rule aligns program requirements where possible to simplify administration of HUD programs. In the case of the PH program, which in some cases requires grievance procedures that are beyond what is required under state/local law, it would be impractical for HUD to seek to fully align the PH program with other HUD rental assistance programs.

Issue: Hearing Postponements. Many commenters objected to language in § 966.56(c), which would limit the timing of any hearing postponements to five days. The commenters stated that the provision places unnecessary time restrictions, and timeframes should remain at the discretion of PHAs on a case-by-case basis.

HUD Response: HUD's intent in this provision is to clarify, through the use of plain language, the flexibility afforded to the hearing officer regarding the length of time for which a hearing may be postponed. The regulatory language was changed from ''not to exceed,'' to ''no more than.'' The change is not substantive, does not reduce the flexibility afforded to the PHA, and is not disadvantageous to the complainant. The final rule is unchanged from the proposed rule.

Issue: Limited English Proficiency (LEP) Requirements. Several commenters expressed concern with the newly included LEP requirements in § 955.56. The commenters asked whether a PHA must provide materials in multiple languages, and stated that PHAs should be allowed to use common sense when providing LEP materials to complainants.

Other commenters asked that HUD expand the LEP requirements beyond written materials to include providing translators at various conferences and meetings and materials in other languages for any notice related to a proposed adverse action. Some commenters stated that written materials may be inappropriate, as some residents may be illiterate in their spoken language.

Some commenters also disagreed with HUD's placement of the LEP requirements under a heading of accommodations for persons with disabilities, as limited English proficiency is not a disability.

HUD Response: HUD's intent in this provision is to clarify in the regulations the LEP requirements already in place for the PH program. On January 22, 2007,[6] HUD published final guidance in the **Federal Register**. This rulemaking does not introduce requirements that are beyond what is included in HUD's final LEP guidance. The final rule has been amended to clarify PHA obligations.

HUD agrees with the comments regarding the placement of the language, and has moved the requirement to § 966.56(g).

[6] See *http://www.gpo.gov/fdsys/pkg/FR-2007-01-22/pdf/07-217.pdf.*

Issue: Due Process. Commenters suggested methods to assure due process rights for complainants, including relying exclusively on local courts or limiting the streamlined process only for drug activity. Some commenters stated that PHAs should be required to set forth a basic schedule, including witness lists and supporting documents and limiting the types of testimony a PHA may introduce without allowing cross-examination of witnesses. Commenters also asked that HUD provide additional guidance on how flexible a PHA may be with certain procedures, in order to reduce the exposure of PHAs to legal challenges.

HUD Response: HUD's intent in this rulemaking is to remove overly prescriptive process requirements for PH grievances, where those requirements are not mandated by statute. The changes proposed above either attempt to maintain or add to existing requirements. The changes are not consistent with HUD's intent in this rulemaking; therefore, HUD will not adopt these suggested changes.

Issue: Consultation with Residents in Appointing Hearing Officers. Some commenters expressed concern that the proposal eliminates the requirement for PHAs to consult with residents in appointing hearing officers, stating that it damages residents' rights to impartial hearings.

HUD Response: Requiring a process to consult with residents over the selection of a hearing officer when PHAs ultimately have the final say about whom to select would be an unnecessarily burdensome process requirement, and therefore contrary to the intent of this rulemaking which is to reduce burden. Further, PHAs still may, but are no longer required to, consult with residents about the hearing officer. This suggestion would maintain the current burdensome process and is inconsistent with HUD's intent in this rulemaking. HUD will not adopt this suggestion.

However, in light of these comments, HUD agrees that tenant input into hearing officer selection process can be valuable. Therefore, HUD is requiring that PHAs include their policies for selection of hearing officers in the dwelling lease, which is subject to a 30-day comment period before any changes can be made.

Issue: Informal Settlements. Commenters asked that HUD continue to require the summary of informal settlements, stating that HUD could provide a template in order to reduce administrative burden.

HUD Response: HUD agrees that there is value in the preparation of the

summary, as it provides an opportunity for both parties to prepare for any forthcoming grievance hearing. As such, HUD will not change the previous requirement that a summary be prepared. HUD will explore whether a template summary would be useful at reducing administrative burden for PHAs.

Issue: Meeting Recordings and Transcripts. Commenters stated that HUD should still require PHAs to allow residents to record a meeting and have a transcript made, as elimination of this requirement doesn't ease the burden to the PHA, but it eliminates a benefit for future proceedings.

HUD Response: HUD agrees with this comment and this final rule reinstates language making clear that any party to a grievance may arrange to obtain a hearing transcript, at their own expense.

Issue: Retention of Hearing Officer Decisions. Commenters expressed concern that HUD was eliminating the requirement that PHAs maintain copies of decisions of hearing officers. Commenters stated that the records are important to maintaining transparency for PHAs; the commenters stated that electronic records would reduce burdens for keeping the records.

HUD Response: HUD's regulation at 24 CFR 966.56(b)(1) requires that tenants be afforded a hearing based on relevant facts related to the specific grievance. HUD disagrees that prior decisions are necessarily relevant to the individual facts related to a specific grievance hearing. Further, the retention of such documents is time-consuming and costly for PHAs. The suggested change is inconsistent with HUD's intent in this rulemaking, which is to reduce administrative burden and program costs. Therefore, HUD will not adopt the suggested change.

However, HUD agrees that basic information related to past hearing decisions could be useful for HUD oversight and for ensuring transparency in the process. Therefore, in lieu of the requirement to maintain redacted hearing decisions and making such decisions available to the public, HUD is requiring that PHAs maintain a simple log, as described in forthcoming HUD guidance, that provides basic information on past hearing decisions.

Issue: Informal Hearings. Commenters stated that HUD should reinstate informal hearings prior to a formal grievance in order to avoid more costly formal hearings whenever possible.

HUD Response: This final rulemaking did not eliminate the informal hearing (*i.e.,* informal settlement of grievance) prior to a formal grievance hearing, as initially proposed. Requirements related to the informal hearing are contained in 24 CFR 966.54.

4. Limited Vacancies (§ 990.150)

Issue: Consistency with local vacancy rates. Commenters stated that PHAs should be allowed to maintain vacancy rates that are comparable with that of the jurisdiction. Others asked HUD to set the allowed vacancy rate at not less than 5 percent, as permitted in the LIHTC and Project-Based Rental Assistance (PBRA) programs.

HUD Response: The limited vacancy provision allows for funding for vacancies of up to 3 percent. Five other types of approved vacancies are included in the existing regulation related to particular project circumstances such as modernization, special uses, litigation, disasters, and casualty losses as well as an appeal provision for vacancies due to changing market conditions.

Issue: Effect on small agencies. Some commenters objected to new language that the commenters stated would reduce subsidies to PHAs and could destabilize small agencies. Others stated that the proposal does not allow for consideration of market conditions or specific local conditions for small PHAs, which would hurt struggling agencies.

HUD Response: The proposed language retains the special consideration for PHAs with 100 units or less. HUD's Public Housing Operating Fund (Operating Fund) regulations continue to allow for appeals for changing market conditions and specific local condition.

Issue: Basis for calculation. Commenters asked that vacancies be judged on a PHA-wide basis to permit balance of high-demand areas with others where there is a low demand, because one or two vacancies could cause a vacancy rate over 3 percent. The commenters stated that PHAs should be allowed to manage their portfolio as a single program, similar to the way the private sector would do so.

HUD Response: This clarification of the limited vacancy rule retains the approach that funding is both determined and provided at a project level. The foundation of the transition to asset management, which was adopted by both PHAs and HUD at the time of promulgation of the new Operating Fund rule, was for certain PHAs to migrate away from PHA-level management and funding for those that converted to asset management. Instead, funding, budgeting, accounting, and management are all conducted at the project level. HUD recognizes each PHA's discretion as a property and financial manager of real estate to group buildings to optimize efficient property management and financial viability. The Operating Fund regulations and HUD systems currently allow PHAs to group buildings into a project(s) to best serve the interests of the property and residents.

Issue: Lag time. Commenters objected to the change because occupancy numbers being used are 12–18 months in the past, requiring PHAs to operate on non-applicable past information.

HUD Response: The Operating Fund formula in 24 CFR part 990 is based on use of historical performance data as a basis to fund current year needs. The clarification of the limited vacancy language does not modify the tenure of performance data used to calculate Operating Subsidy eligibility.

Issue: Negotiated rulemaking. Some commenters stated that HUD should stand by agreements reached through the negotiated rulemaking process that established the current operating fund formula.

HUD Response: The clarification of the limited vacancies provision is consistent with the negotiated rulemaking process.

5. Flat Rents (§ 960.253)

Issue: Phase-in of rent increases less than 35 percent. Commenters asked that HUD reinstate an earlier policy that would allow PHAs to use discretion in implementing any higher flat rents. This would have allowed PHAs to phase in small flat rent increases—those below 35 percent—over a three-year period.

HUD Response: The initial discretion for phasing in small increases was due to the fact that the changes in the 2014 Appropriations Act set all flat rents at 80 percent of FMR, with no possibilities for exceptions to that amount. HUD received indications that this might be softened in a future year, permitting PHAs to set flat rents using more localized market data. As a result, HUD used its discretion to limit the impact of flat rent changes on PHAs and tenants by allowing the higher rents to be phased in.

With the passage of the 2015 Appropriations Act, however, HUD believes that PHAs have sufficient flexibility to set flat rents that reflect the true market value of their units, and therefore the three-year phase-in for small flat rent increases is unnecessary. However, the statutory requirement to phase in increases exceeding 35 percent for families already paying flat rents remains in the rule.

Issue: Deadline for compliance. Commenters asked HUD to extend the

January 1, 2016 deadline for flat rents to take effect.

HUD Response: This comment misinterprets the effective date of the new flat rent requirements. HUD did not establish a hard deadline of January 1, 2016 for new flat rents to take effect. PHAs were already required to establish flat rents at no less than 80 percent of the applicable FMR as required by PIH Notice 2014–12. That notice clarified that PHAs were required to update flat rents no later than 90 days after HUD published new, final FMRs. The 90-day effective date of new flat rents based on new FMRs was also included in the interim rule and the accompanying guidance provided through notice PIH 2015–13. Once HUD publishes new final FMRs in any given year, PHAs will be required to update flat rents within 90 days of the publication of those FMRs and must begin applying them prospectively to new admissions and at family annual recertifications. In years where HUD takes longer than 12 months between the publication of new FMRs, PHAs are permitted to continue to charge flat rents at the current FMR, SAFMR, or approved exception flat rent amount until HUD publishes new FMRs and the 90-day effective date has taken place.

Issue: Lowering rents when FMRs or SAFMRs decrease. Commenters asked HUD for additional clarity on the requirements for when market rents decrease, particularly whether PHAs retain discretion to reduce flat rents when FMRs decrease.

HUD Response: PHAs must set flat rents at no less than 80 percent of the FMR or SAFMR, or they may submit an exception request establishing flat rents based on a market analysis. There is no such requirement limiting a PHA from lowering a flat rent in years where the FMR or SAFMR decreases. Therefore, in years where an FMR or SAFMR decreases, PHAs have the discretion to lower flat rents, but they may not set flat rents at less than 80 percent of the FMR or SAFMR unless they submit a new exception request.

Issue: Rent reasonableness guidance. Commenters suggested that a possible explanation for why flat rents have been set incorrectly in the past is due to a lack of guidance from HUD on proper rent reasonableness assessments.

HUD Response: While that may be true for some PHAs, HUD has heard anecdotally that there were many reasons why flat rents may not have been set correctly. However, in an effort to support PHAs when trying to determine the market value of their public housing, HUD will publish future guidance on rent reasonableness assessments for public housing.

Issue: Updating rent levels when an exception rent has been requested. Commenters asked for additional clarification on what the requirements were related to adjusting flat rent levels when the PHA is intending to submit a request for exception rents.

HUD Response: In this initial year, any PHAs that submit exception requests prior to the expiration of the 90-day period after the publication of new FMRs may continue to charge flat rents at the current levels until the PHA is notified of HUD's decision on their exception request. However, if a PHA fails to submit an exception request prior to the expiration of the 90 day period after the publication of new FMRs, that PHA may still submit an exception request, but must update flat rents to no less than 80 percent of the FMR or SAFMR until such time that HUD notifies the PHA of its decision on the exception request.

Issue: Flat rents and self-sufficiency. Commenters stated that PHAs should have the discretion to set flat rents lower than 80 percent of market rents in order to encourage families to become self-sufficient.

HUD Response: Flat rents themselves are intended to encourage self-sufficiency. They are a maximum amount of rent that a family could be charged; once a family begins to pay flat rent, any increases in income do not have an effect on their rental payment. Because families have the ability to choose between paying an income-based rent or a flat rent, families that choose to pay flat rents are inevitably paying a lower percentage of income than other public housing households which is a self-sufficiency incentive. Therefore, HUD does not believe that any additional discretion regarding flat rents is necessary to encourage economic self-sufficiency.

Issue: Reduced exception rent requests. Commenters asked that PHAs only be required to submit exception rent requests every three years instead of annually.

HUD Response: HUD is bound by the statutory framework, which stipulates that exception requests must be submitted if the applicable FMR or SAFMR do not reflect the market value of a property. As such, the statute requires a comparison of the FMR or SAFMR to a current market study in order to determine whether the market value of a property is less than the current FMR or SAFMR. Therefore, HUD does not have the authority to permit PHAs to use market studies that are not current for exception requests.

Issue: LIHTC rents and public housing flat rents. Commenters asked for additional clarity on how the flat rents regulation impacts the LIHTC rents.

HUD Response: PHAs that manage public housing units that were developed or modernized using LIHTC must set maximum rents for such units at the required maximum LIHTC rents, even if this is lower than the minimum flat rent amount for a particular unit.

Issue: Opposition. Several commenters objected to the flat rent policy entirely, stating that it would increase rent burden, cause higher turnover, and negatively impact tenant employment.

HUD Response: Although HUD recognizes that there are consequences to changes in flat rents, HUD believes that the changes included in the FY 15 Appropriations Act, which have been included in this rulemaking, provide sufficient flexibility to PHAs to set accurate, market-based rents. Further, tenants concerned about rent burden are reminded that they are provided a safeguard in this rulemaking from large annual increases in rent, and they are always able to elect to pay the income-based rent which is set at 30 percent of income.

D. HCV Program Regulations

1. Start of Assisted Tenancy (§ 982.309)

Issue: Objections. Many commenters objected to this proposal, stating that landlords seek to lease units as quickly as possible, and this could delay tenants from being able to move into their units. In high-demand areas, this could reduce the number of landlords willing to participate in the voucher program, limiting choice to voucher holders. Many commenters also expressed concern that this would have negative consequences for families that need to move immediately or alternatively would cause tenants to have to move out of a unit before being able to move into a new one. Other commenters stated that this would concentrate administrative tasks into a single time of the month for PHAs, actually increasing their burden.

HUD Response: HUD has decided against promulgating this change. Several commenters favored the proposed change, but input from groups ranging from landlords to tenant advocates suggested that the change would have an adverse effect on the ability of HCV-assisted tenants to access housing. While the proposed change would have been optional at the discretion of the PHA, and HUD estimates that PHAs would choose not to adopt any measure that would make

it more difficult for HCV-assisted tenants to access housing, HUD ultimately decided that it could move forward with the change only if it also required any PHA opting to implement the provision to also put into place an exception policy for certain families (*e.g.,* victims of domestic violence) or situations (*e.g.,* HAP terminations due to HQS violations). Ultimately, requiring the adoption of an exception policy would counter any administrative relief provided by implementing the proposed change. Taking all of these factors into consideration, HUD declines to include this provision in this final rule.

2. Biennial Inspections and the Use of Alternative Inspection Methods (§§ 982.405, 983.103)

Issue: HUD Systems. Commenters suggested ways that HUD could improve its inspection procedures. Some commenters suggested that the electronic systems be updated for biennial inspections, and others asked for a centralized database for inspection reports and data, which could then be accessed by PHAs in order to obtain the results of alternative inspection methods. Some commenters stated that HUD should review inspection protocols with input from PHAs and implement ''best practices'' across the board. Commenters also asked for consolidating inspection standards between HUD programs and LIHTC.

HUD Response: While these comments are helpful in that they specify improvements to HUD systems that would simplify the inspection process, advise of the burden that results from differences in inspection protocols and standards, and point out at least one way in which an expansion of this provision could bring about further streamlining, they are either beyond the scope of this rulemaking or would require statutory changes.

In addition, HUD's information technology investment decisions are made enterprise-wide based on available resources as appropriated by Congress. HUD will explore ways to move to electronic reporting systems with available resources. In particular, HUD is considering the creation of a national-level affordable housing database that could be utilized in the way described.

Issue: Keep Proposal Optional. Some commenters stated that PHAs may want to inspect properties more frequently for oversight purposes, and therefore asked that biennial and alternative inspections remain optional for PHAs.

HUD Response: As authorized by Congress and proposed in this rulemaking, the use of biennial inspections is at the discretion of the PHA; PHAs will retain the discretion to inspect annually any properties that warrant more frequent attention. The same is true of alternative inspection methods—their use is entirely at the discretion of the PHA, per the statute and this rulemaking. Nothing in this final rule requires a PHA to adopt biennial inspections or alternative inspection methods.

Issue: Remediation Protocols. Commenters offered several suggestions on how to remediate problems identified by alternative inspections. Some stated that HUD should allow PHAs to rely upon the remediation protocol of the alternative inspection method; there would be no burden relief if PHAs have to conduct HQS inspections anyway for units that failed the alternative inspection the first time. Some commenters suggested that this could be satisfied by providing HUD with a certification from the inspecting agency that the deficiencies have been mitigated. Commenters stated that HUD should allow PHAs to decide if they will conduct a remedial HQS inspection or rely on the owner to provide proof of actions to remedy defects.

HUD Response: HUD is sympathetic to the suggestion that any streamlining benefit of this provision is offset by the requirement that a PHA inspect a property using HQS when the property has already been inspected using an alternative inspection method and such method reveals the existence of violations that would have resulted in a ''fail'' score under HQS. For an alternative inspection method that employs sampling, however, as is the case with inspections of properties subsidized with LIHTCs, any cited deficiencies that would ultimately be corrected may exist as well in units not included in the sample, including units occupied by HCV-assisted households. HUD has an obligation to determine whether such deficiencies exist in units occupied by such households and, if they do, to assure that the units are once again brought into compliance with HUD's housing quality standards.

PHAs are only precluded from relying on an alternative inspection method if a property inspected pursuant to the method fails an inspection. In all cases where a property passes an inspection, even if deficiencies are identified, a PHA may rely upon the alternative inspection method to demonstrate compliance with HUD's housing quality standards. If a property fails an inspection due to identified deficiencies, it may be the case that remedial actions taken pursuant to the alternative inspection method fall short of what would be required under HUD's housing quality standards.

In any circumstance in which a PHA is prohibited from relying on an alternative inspection method, HUD declines, for the reasons identified above, to adopt alternative remediation measures as a substitute for a PHA's determination that a unit occupied by an HCV-assisted family meets the requirements for occupancy and funding under the HCV program.

Issue: Reinspection Sampling. In the case of residents with tenant-based vouchers living in mixed-finance properties, commenters stated that HUD should authorize biennial inspection of a random sample of units consisting of at least 20 percent of the contract units in each building.

HUD Response: Congress specifically authorized the use of alternative inspections, including inspections conducted pursuant to requirements under the low-income housing tax credit (LIHTC) program. The LIHTC program employs sampling. A PHA may adopt an alternative inspection method that is specifically authorized by Congress or approved by HUD and employs sampling.

Issue: Alternative Inspection Standards. Commenters suggested that HUD require HUD's Real Estate Assessment Center (REAC) to approve or disapprove a PHA's certification that an alternative inspection method meets HUD standards prior to allowing the PHA to employ the alternative inspection method.

HUD Response: HUD has adopted this suggestion in this final rulemaking.

Issue: Local Jurisdiction Inspections. Commenters asked that HUD allow PHAs to use inspections done for local jurisdictions, even when the inspections are done by local agencies.

HUD Response: The statute authorizes PHAs to rely on inspections conducted under a ''Federal, state, or local housing program.'' HUD interprets a ''local housing program'' to include a local housing code. Subject to the conditions established in this final rule, a PHA may rely upon an inspection conducted pursuant to a local housing code to meet its obligation to inspect units occupied by HCV-assisted tenants during the course of a housing assistance payments contract. In order to rely upon such an inspection, a PHA must submit a copy of the local housing code to HUD, along with an analysis by the PHA showing that the local housing code standard meets or exceeds HQS. Once HUD has reviewed these materials, and then only if HUD approves use of the inspection method, the PHA may rely upon it. The PHA must certify annually to HUD that

the local housing code has not changed; if it has changed, then the PHA must again obtain HUD approval to rely upon the standard, submitting a copy of the revised code and an analysis showing that the revised standard meets or exceeds HQS.

Issue: Objections. Some commenters expressed dissatisfaction with the proposal, particularly with alternative inspections, and stated that HUD should not continue with the proposal.

HUD Response: HUD is required by law to implement biennial inspections and inspections via alternative inspection methods.

3. Housing Quality Standards (HQS) Reinspection Fees (§ 982.405)

Issue: Burden on PHAs and Deterrence to Landlords. Some commenters objected to the proposal, stating that landlords would be reluctant to pay reinspection fees and would therefore be deterred from participating in the Section 8 program. Others stated that charging fees to landlords would be a burden to PHAs, and therefore should remain optional and up to the PHA to decide how to implement.

HUD Response: The proposed change made it optional for a PHA to charge a reinspection fee, and this final rule retains the optional nature of the provision. If a PHA has a concern that charging a fee may deter landlords from participating in the program or may result in additional work (*i.e.,* securing payment of a fee, once assessed), then the PHA will want to take these factors into consideration when determining whether to impose a reinspection fee. As long as a PHA complies with the requirements of this regulation when imposing a reinspection fee, nothing in this regulation would constrain a PHA from adopting local policies specific to the administration of such a fee. For example, a PHA could specify in its Administrative Plan that an owner will be charged a reinspection fee only after a second reinspection reveals that the defect persists. PHAs will need to determine whether and how best to use this reinspection fee authority, based upon their local circumstances.

Issue: Use of Fees and When to Charge. Some commenters suggested that the collected fees be added to administrative fee amounts available to a PHA.

HUD Response: Fees will be included in a PHA's administrative fee reserve and may be used only for activities related to the provision of Section 8 tenant-based assistance.

Issue: Guidance. Several commenters asked HUD to provide additional guidance on what constitutes a ''reasonable'' fee; such guidance will be necessary to reduce PHA administrative burden.

HUD Response: HUD will issue guidance on what constitutes a ''reasonable'' fee.

Issue: When Charges May Be Assessed. Commenters asked that HUD clarify the proposal to avoid charges for full HQS inspections instead of merely for reinspections of previously identified deficiencies. Others asked for information on how the proposal would relate to special inspections that are not initial or regularly scheduled inspections, or what would happen if a landlord or tenant does not attend or allow entrance for the inspection. Commenters also asked that HUD expand the proposal to allow for the charging of fees even when a landlord has not indicated deficiencies have been corrected, when the allotted time for repairs has expired but a pre-scheduled reinspection reveals the repairs have not been made.

HUD Response: The final rule makes clear that a fee may be assessed under two circumstances: First, if a landlord affirms that a repair has been made and a subsequent reinspection shows that it has not and, second, when the allotted period of time for making the repair has lapsed and a reinspection shows that the repair has not been made, whether or not the landlord has affirmed that it was.

Issue: Expansion of Proposal. Some commenters also suggested that HUD expand the proposal to allow for fees for all reinspections. Others stated that PHAs should be allowed to redirect funds from abated rents to cover the costs of inspections instead of charging fees. Finally, commenters stated that HUD should consider other incentives for landlords, such as allowing tenants to pay rent into repair escrow accounts.

HUD Response: HUD appreciates these suggestions and observations but has declined to adopt them as part of this rulemaking.

4. Exception Payment Standards for Providing Reasonable Accommodations (§§ 982.503, 982.505)

Issue: Unit Special Features. Commenters stated that HUD should include a consideration of special features of the unit when establishing a reasonable rent between 110 percent and 120 percent of area fair market rent (FMR).

HUD Response: There was strong support for retaining this provision unchanged, and HUD has done so. A PHA must take special features into consideration when there is a reasonable accommodation request. In accordance with 24 CFR part 8, a PHA must provide a higher payment standard if requested as a reasonable accommodation for a family that includes an individual with disabilities. HUD's regulation implementing section 504 of the Rehabilitation Act, at 24 CFR part 8, is referenced in 24 CFR 982.505(d). In addition, under 24 CFR 8.28(a)(3), PHAs are already required, when issuing a voucher to a family that includes an individual with disabilities, to assist the family in locating an available, accessible dwelling unit. For example, PHAs are required to provide a current listing of available units known to the PHA.

Issue: HAP Funding. Commenters stated that PHAs will be challenged to provide higher payment standards when HAP funding is already constrained.

HUD Response: HUD acknowledges the concerns about funding constraints. PHAs are nonetheless required to assist families that include an individual with disabilities, including by providing a higher payment standard as a reasonable accommodation, if the family requests such an accommodation and it is necessary in order for the family to obtain suitable housing.

5. Family Income and Composition: Regular and Interim Examinations (§ 982.516(c)–(e))

Issue: Timing of Interim Examinations. Commenters supported this proposal, but also asked that it remain optional for PHAs. Some asked for further clarification from HUD regarding whether a PHA is required to conduct an interim examination when a family member is added, and at what point such an examination might be required. Several commenters also pointed out that the new proposed language did not align regulations between the PH and Section 8 programs.

HUD Response: HUD agrees with providing clarity to the proposed change to 24 CFR 982.516. With the removal of paragraph (e) (''Family member income''), HUD is removing from part 982 the requirement that a PHA perform an interim examination whenever a new family member is added. The corresponding regulation for the PH program (24 CFR 960.257) contains no such requirement. The removal of paragraph (e) from § 982.516 provides HUD with the opportunity to issue uniform guidance on interims—in other words, guidance that will apply to both the PH and HCV programs. Having reviewed data on the reasons for which interims are requested and considering a number of alternatives, including establishing thresholds below which

PHAs would not be required to conduct interims, HUD determined that the greatest potential for streamlining lies in issuing uniform guidance. Other options either created their own administrative challenges and/or had the potential to have a negative effect on program participants. For example, authorizing PHAs to limit interims to circumstances in which a change in family income or composition would result in a rent increase of some threshold dollar amount would require PHAs to determine whether the threshold had been met, which would in itself be a burdensome exercise. At the same time, a finding that the threshold had not been met, resulting in no change to a family's rent, could place a burden on tenants.

Issue: Discretion and Threshold Amounts. Several commenters requested that HUD continue to leave policies regarding recertifications up to the discretion of PHAs.

HUD Response: Nothing in this final rule alters PHA discretion with respect to interims.

6. Utility Payment Schedules (§ 982.517)

Issue: Objections to the Proposal. Many commenters objected to the proposal to consolidate the utility payment schedules. Some commenters stated that the definition of ''attached'' and ''detached'' are unclear, and HUD should provide additional information. Other commenters stated that consolidating the schedules would penalize tenants in certain types of units because energy use is not always comparable under such broad categories. Some commenters suggested that the proposal could raise fair housing issues by impacting larger families in multi-bedroom units. Others stated that the proposed 60-day notice was insufficient to protect tenants from decreased utility allowances.

Some commenters stated that, in areas served by more than one PHA, perhaps with differing policies on how to define unit types, the proposal would create confusion for program applicants and participants.

HUD Response: Considering the totality of the comments submitted on the proposal to authorize PHAs to establish utility payment schedules that limit ''unit type'' to either ''attached'' or ''detached,'' HUD has decided against adopting this provision. HUD acknowledges comments that the proposal may have an unintended and inequitable effect on certain households, and believes this issue merits additional analysis in order to determine the extent to which these outcomes may occur and to weigh those outcomes against the benefits of streamlining. In addition, comments focused on jurisdictional questions caused HUD to realize that the proposal could create confusion—for program applicants, especially—in the event PHAs with overlapping jurisdictions opted to adopt different definitions of ''unit type'' (*i.e.,* one relying on the traditional method and the other choosing to define unit type as either ''attached'' or ''detached'').

Issue: Broader Utility Allowance Changes. Commenters asked HUD to consider broader changes to utility allowances. Commenters suggested that HUD completely eliminate utility allowance schedules or allow flat utility allowances based on average per-bedroom size or household size. Others suggested that HUD provide an annual utility cost adjustment factor for each locale instead of requiring PHAs to calculate utility costs on their own. Finally, some commenters suggested that HUD establish a more equitable utility subsidy approach, accounting for other forms of assistance, such as utility caps or utility credits.

HUD Response: Based on comments received, HUD recognizes that having a holistic look at utility allowance calculations may be merited. Should HUD initiate such a review, these comments will be taken into consideration. The suggestions are, however, beyond the scope of this rulemaking.

E. Other Comments

In addition to comments on specific proposals, commenters also suggested regulatory and other changes that HUD could make for streamlining and other burden-reducing benefits.

1. Enterprise Income Verification (EIV)/ Information Verification

Issue: EIV Reports. Some commenters suggested that certain reports (*e.g.,* New Hires, New Move-In, Income Discrepancy) should not be used as frequently, if at all. The commenters suggested that, to the extent such reports provide useful information, the information could be gathered at other times or using other methods.

HUD Response: HUD appreciates the comments regarding the use of the various EIV reports. HUD understands that the information generated through some reports may reflect delayed information. However, EIV has significantly reduced improper payments in HUD's programs, and these reports help PHAs and HUD to monitor program participants and address discrepancies in a timely manner. Further, changes to EIV are beyond the scope of this rulemaking.

Issue: EIV Use and Expansion. Many commenters suggested that HUD modify the EIV system by adding additional income sources, including past income, in the system or allowing verification of SSNs through EIV. Other commenters suggested that HUD consider alternatives to EIV, such as the Work Number or cooperative agreements with state agencies. Finally, commenters asked for more frequent updates to EIV.

HUD Response: HUD appreciates the comments about how to improve or supplement EIV; however, these suggestions are outside of the scope of this rulemaking.

2. Income Determinations and Rent Settings

Issue: Calculation of Income. Commenters offered suggestions on ways that they stated would be easier to calculate tenant income and rent. Some stated that HUD should base rents on gross income, rather than adjusted income. Others suggested that HUD modify the process for deducting medical expenses from income by using past expenses or a standard deduction. A standard childcare deduction was also proposed. One commenter suggested that HUD consider the automation-based process for certification and verification incorporated by the Affordable Care Act.

Commenters also asked HUD to allow for less frequent income reexaminations, either on a biennial or a triennial basis. This change could be authorized based on family type (*i.e.,* elderly, disabled) or family income status (*i.e.,* extremely low-income, very low-income).

Some commenters requested an increase in the minimum rent or that HUD reinstate the ''frozen rental income'' regulation provision to encourage tenants to have earned income. Others asked that HUD consider limiting the inclusion of assets by only including actual income from assets or only including assets disposed of for less than fair market value for assets over a given threshold. Some stated that HUD should count assets disposed of since the two previous annual reexaminations instead of the previous two years.

Commenters stated that HUD should not allow tenants to claim no income, but instead should require that all tenants maintain a minimum income.

Finally, commenters stated that PHAs should not be required to conduct rent reasonableness determinations when a PHA is using a fair market rent determined by HUD or when a proposed rent has already been approved by HUD or its administrator.

HUD Response: HUD requested comments from the public about other opportunities to align requirements across programs, and HUD appreciates receiving these additional comments. Some of the suggestions are outside the scope of this rulemaking or would require statutory change. However, HUD will consider these suggestions for future streamlining changes.

HUD has taken actions on other suggestions. HUD's FY 2016 budget proposes three-year recertification of income for fixed income families, increasing the threshold for deduction of medical and related care expenses, and a Utilities Conservation Pilot that would make it easier for PHAs to access energy incentives from energy investments. Also, HUD is conducting a rent reform demonstration to compare the current rent structure in subsidized housing to an alternate structure in terms of impact on household employment, earnings, hardship, homelessness, and on simplification and cost of PHA administrative processes.

3. Fees and Payments

Issue: Funding and Improper Payments. Many commenters provided suggestions on how to improve and streamline payments to owners and PHAs. Several suggested increased funding for administrative fees or physical inspections. Other commenters stated that HUD should permit voucher HAP reserves to be used for administrative purposes when the administrative fee proration is below 90 percent.

Some commenters requested HUD freeze the rolling utility base to allow PHAs to recoup savings from energy conservation methods. Others asked HUD to allow expedited implementation of lower payment standards in the voucher programs. Several commenters suggested that HUD revise its process for determining project expense levels, accounting for the age of properties and using the negotiated rulemaking inflation factor. One commenter stated that HUD should permit rent increases to owners in the HCV program only on a contract anniversary date.

Commenters also provided suggestions on reforming improper payment procedures. A commenter asked that HUD not require owners to provide proof of the costs involved in recovering improper payments. Commenters also suggested that HUD not specify what makes repayment of improper payments ''affordable'' to residents, as the current definition is confusing and leads to extra work for staff.

HUD Response: As is the case on HUD's response to the preceding issue, many of the comments are outside the scope of this rulemaking or would require action by Congress, but HUD will consider these for future streamlining changes. With respect to freezing the rolling base to allow PHAs to recoup savings from energy conservation methods, this is permitted now when a PHA has entered into an energy performance contract.

4. Miscellaneous Suggestions

Issue: Broader Streamlining and Other Suggestions. Many commenters had specific suggestions on how to align requirements and processes across programs. Some suggested that HUD use the Public Housing Administrative Reform Initiative to find some additional streamlining suggestions. Others stated that HUD should have just a single entity review grantee compliance with various program requirements instead of allowing multiple agencies to have oversight.

Some commenters asked HUD to modify inspection protocols, including by explicitly stating that a physical reinspection of deficiencies is not required. Others stated that HUD should not use the Uniform Physical Conditions Standards for HCV, but should continue to use the HQS. Commenters further asked that HUD reconsider the requirement that failed HQS items be reinspected prior to the HAP contract effective date, instead allowing families to move in while the owner has 30 days to repair the failed items.

Commenters also stated that HUD should limit requirements under section 3 of the 1937 Act to only programs under the Office of Housing. Others asked that HUD institute a threshold of activity below which Section 3 requirements would not apply.

Some commenters asked that eligibility and reporting procedures be standardized across housing programs both in HUD and across other Federal agencies. Others stated that HUD should extend the zero-subsidy time limit for voucher holders to align policies between the voucher and PBRA programs. Many commenters also stated that HUD should allow PHAs the discretion on whether or not to require community service in PH, as it is not required in other HUD programs.

A commenter stated that HUD should incorporate policies from the Multifamily Handbook into the PH and voucher programs to provide additional information on how a PHA should consider a tenant family's circumstances when they fail to recertify in a timely manner.

Some commenters stated that HUD should allow PHAs to be eligible for Housing Trust Fund money for PH rehabilitation. Others asked that HUD clarify that PHAs with 250 or more units of PH are still able to use operating reserves for capital improvements.

Commenters also asked for clarity on the HCV Tenancy Addendum and on qualifying for the Capital Fund Activity exclusion for environmental assessments.

HUD Response: HUD will take these suggestions into consideration as it seeks to identify additional opportunities to reduce the administrative burden on PHAs and owners and to align the requirements across programs, where feasible. The majority of these suggestions is beyond the scope of this rulemaking, or would require statutory change. However, for others, HUD can address through administrative guidance. With respect to the suggestion that HUD thoroughly review the final report of the Public Housing Administrative Reform Initiative, this report is among the documents initially reviewed by HUD's streamlining working group, which ultimately initiated this rulemaking.

Issue: Regulatory Relief in Property Assessment. Several commenters asked HUD to suspend PHA plan requirements or for a moratorium on the Physical Needs Assessment. Commenters asked for waivers of asset management regulations affecting funding, such as cash transfers between properties, fee caps, and Asset Management Project (AMP) configurations. Commenters further asked for broad waivers under 24 CFR part 5 and for the Public Housing Assessment System and Section Eight Management Assessment Program to be advisory only for non-statutory items. Finally, commenters stated that HUD should ensure that PHAs are fully trained before any changes go into effect.

HUD Response: HUD remains interested in identifying opportunities to reduce the burden on PHAs, owners, and grantees that administer rental assistance. While the suggestions provided here are outside the scope of this rulemaking, they are helpful in identifying for HUD areas on which to focus attention. HUD will continue to look for opportunities to streamline and simplify the administration of its programs, and to align the requirements across programs, to the extent feasible and reasonable, applying the same lens to future proposals as it employed for this rulemaking effort. Specifically, any

proposal to relieve the administrative burden on PHAs, owners, and grantees will need to be balanced against important tenant protections and HUD's obligation to provide program oversight. With respect to guidance and training, HUD is aware that PHAs, owners, and grantees may have questions about how best to implement several of the provisions in this rule. HUD will provide opportunities to address those questions, through additional written guidance, training, and other means that enable HUD to respond to requests for information.

Issue: Statutory Changes. Commenters requested changes that they acknowledged would require congressional action. These proposals include an earned income deduction for all families, eliminating voucher portability, expanding Moving to Work, the Small Housing Authority Reform Proposal, triennial recertification for fixed-income families, increasing the flat deduction for elderly families or persons with disabilities, increasing the medical expense deduction, or eliminating eligibility differences among programs.

HUD Response: For several of these suggestions, HUD has previously sought statutory change. In its FY14 budget proposal, for example, HUD included several statutory changes that were ultimately enacted by Congress and have now been implemented with the publication of this final rule. HUD will continue to look for opportunities to streamline and simplify the administration of its programs, and to align the requirements across programs, to the extent feasible and reasonable, applying the same lens to future proposals as it employed for this rulemaking effort. Specifically, any proposal to relieve the administrative burden on PHAs and owners will need to be balanced against important tenant protections and HUD's obligation to provide program oversight.

IV. Findings and Certifications

Executive Orders 12866 and 13563, Regulatory Planning and Review

Under Executive Order 12866 (Regulatory Planning and Review), a determination must be made whether a regulatory action is significant and, therefore, subject to review by the Office of Management and Budget (OMB) in accordance with the requirements of the order. Executive Order 13563 (Improving Regulation and Regulatory Review) directs executive agencies to analyze regulations that are ''outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them in accordance with what has been learned.'' Executive Order 13563 also directs that where relevant, feasible, and consistent with regulatory objectives, and to the extent permitted by law, agencies are to identify and consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public. This rule was determined to be a ''significant regulatory action'' as defined in section 3(f) of Executive Order 12866 (although not an economically significant regulatory action, as provided under section 3(f)(1) of the Executive Order).

As already discussed in this preamble, the regulatory changes by this streamlining rule are designed to reduce administrative burdens on PHAs, enable PHAs to better target assistance to families, and reduce Federal costs. Some of the changes in this rule are due to statutory changes enacted in the FY 2014 Appropriations Act and have specific estimates of financial savings that may be expected (specifically the change in the definition of ''extremely low-income'' and the cap on the utility allowance). Other changes (biennial inspections, streamlining income recertifications) may have estimates on savings generated by Moving-to-Work (MTW) agencies that already implemented such flexibilities. Some provisions of this rule, however, focus solely on providing or revising regulatory provisions that reduce administrative burdens on PHAs, but that are optional for PHAs to utilize. Consequently HUD is unable to quantify costs and benefits for this rule overall because of the flexibility provided.

The rule provides PHAs with the discretion as to whether they will implement those regulations that provide alternatives means of implementing several required administrative actions. HUD recognized that there is a need for greater flexibility for PHAs to operate programs that fit their communities and to use savings generated in time from these provisions to better focus resources on their operational priorities. However, savings are difficult to estimate as the changes are not mandatory. HUD's FY2015 budget estimated Federal savings for two of the provisions, changing the definition of ''extremely low-income'' and placing a cap on the utility allowance. HUD's budget did not contain savings estimates for other provisions which would yield efficiencies for PHAs, not HUD. For the provision permitting biennial inspections, savings data comes from Moving-to-Work (MTW) agencies experiences and reporting.

In FY2015, HUD estimated that the revised definition of extremely-low income will reduce Federal costs by an estimated $155 million. The change increases access to HUD rental assistance for working poor families, in rural areas in particular. In such areas, median incomes are often so low that families with a fulltime worker have incomes that exceed 30 percent of AMI, even though the families remain below the Federal poverty level. In the voucher program in particular, where 75 percent of vouchers issued each year must be targeted to ELI families, this change will enable more working poor families to qualify for voucher assistance.

Additionally, HUD estimated in its FY2015 budget that limiting the utility allowance payment for tenant-based vouchers to the family unit size for which the voucher is issued, irrespective of the size of the unit rented by the family, will generate estimated savings of $50 million.

Permitting biennial inspections for HCV units will reduce the administrative and financial burden on PHAs and high-performing landlords and enable PHAs to concentrate their inspection resources on the more marginal and higher-risk units. Of the 34 MTW agencies, 23 have adopted or proposed to adopt biennial inspection schedules. The Cambridge Housing Authority estimated a net savings of $122,234, or more than 3,737 hours of staff time in 2014 compared to 2008. The Housing Authority of the County of San Mateo reduced the number of inspections to approximately 2,086 annually from 4,172 and reported savings of $52,150 in inspection costs. HUD believes that PHAs adopting this flexibility will experience similar savings in time and costs.

Determining the complete amount of financial and time savings for this rule is difficult because, as noted, the majority of the provisions are discretionary for PHAs, and HUD believes that each PHA will evaluate its own circumstances in financing and staffing and adopt those provisions that are most cost-effective for them.

Executive Order 13132, Federalism

Executive Order 13132 (entitled ''Federalism'') prohibits an agency from publishing any rule that has federalism implications if the rule either imposes substantial direct compliance costs on state and local governments and is not required by statute, or the rule preempts state law, unless the agency meets the consultation and funding requirements of section 6 of the Executive Order. This final rule does not have federalism implications and does not impose

substantial direct compliance costs on state and local governments nor preempt state law within the meaning of the Executive Order.

Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*) generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements, unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. This rule reduces the administrative burden on PHAs, MFH owners, and certain CPD grantees in many aspects of administering assisted housing. Such PHAs, MFH owners, and CPD grantees, regardless of size, will benefit from the burden reduction proposed by this rule. These revisions impose no significant economic impact on a substantial number of small entities. As discussed above, many of the new provisions are voluntary, and each PHA or MFH owner will be able to adopt the streamlining provisions that offer the greatest benefit to them, further reducing any negative effects on small entities. Therefore, the undersigned certifies that this rule will not have a significant impact on a substantial number of small entities.

Environmental Impact

A Finding of No Significant Impact with respect to the environment was made on the proposed rule in accordance with HUD regulations in 24 CFR part 50 that implement section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)(C)). The Finding remains applicable to this final rule. The Finding is available for public inspection during regular business hours in the Regulations Division, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW., Room 10276, Washington, DC 20410–0500. Due to security measures at the HUD Headquarters building, please schedule an appointment to review the Finding by calling the Regulations Division at 202–708–3055 (this is not a toll-free number). Individuals with speech or hearing impairments may access this number via TTY by calling the Federal Information Relay Service at 800–877–8339.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) establishes requirements for federal agencies to assess the effects of their regulatory actions on state, local, and tribal governments and the private sector. This rule will not impose any federal mandates on any state, local, or tribal governments or the private sector within the meaning of UMRA.

Paperwork Reduction Act

The information collection requirements contained in this rule have been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520) and assigned OMB control numbers 2577–0220 and 0169. In accordance with the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers applicable to the programs that would be affected by this rule are: 14.103, 14.123, 14.135, 14.149, 14.157, 14.181, 14.195, 14.235, 14.241, 14.326, 14.850, 14.871, and 14.872.

List of Subjects

24 CFR Part 5

Administrative practice and procedure, Aged, Claims, Crime, Government contracts, Grant programs—housing and community development, Individuals with disabilities, Intergovernmental relations, Loan programs—housing and community development, Low and moderate income housing, Mortgage insurance, Penalties, Pets, Public housing, Rent subsidies, Reporting and recordkeeping requirements, Social security, Unemployment compensation.

24 CFR Part 880

Grant programs—housing and community development, Rent subsidies, Reporting and recordkeeping requirements.

24 CFR Part 884

Grant programs—housing and community development, Rent subsidies, Reporting and recordkeeping requirements, rural areas.

24 CFR Part 886

Grant programs—housing and community development, Lead poisoning, Rent subsidies, Reporting and recordkeeping requirements.

24 CFR Part 891

Aged, Grant programs—housing and community development, Individuals with disabilities, Loan programs—housing and community development, Rent subsidies, Reporting and recordkeeping requirements.

24 CFR Part 903

Administrative practice and procedure, Public housing, Reporting and recordkeeping requirements.

24 CFR Part 960

Aged, Grant programs—housing and community development, Individuals with disabilities, Pets, Public housing.

24 CFR Part 966

Grant programs—housing and community development, Public housing, Reporting and recordkeeping requirements.

24 CFR Part 982

Grant programs—housing and community development, Grant programs—Indians, Indians, Public housing, Rent subsidies, Reporting and recordkeeping requirements.

24 CFR Part 983

Grant programs—housing and community development, Rent subsidies, Reporting and recordkeeping requirements.

24 CFR Part 990

Accounting, Grant programs—housing and community development, Public housing, Reporting and recordkeeping requirements.

Accordingly, for the reasons stated in the preamble, HUD amends 24 CFR parts 5, 880, 884, 886, 891, 903, 960, 966, 982, 983, and 990 as follows:

PART 5—GENERAL HUD PROGRAM REQUIREMENTS; WAIVERS

■ 1. The authority citation for part 5 continues to read as follows:

Authority: 42 U.S.C. 1437a, 1437c, 1437d, 1437f, 1437n, 3535(d), Sec. 327, Pub. L. 109–115, 119 Stat. 2936, and Sec. 607, Pub. L. 109–162, 119 Stat. 3051.

■ 2. Amend § 5.216 as follows:
■ a. Designate the second paragraph (g)(1)(ii) as paragraph (g)(1)(iii);
■ b. Revise paragraph (h)(1);
■ c. In paragraph (h)(2), remove the phrase ''paragraph (h)(1)'' and add in its place ''paragraph (g)(1)''; and
■ d. Add paragraph (h)(3).

The revision and addition read as follows:

§ 5.216 Disclosure and verification of Social Security and Employer Identification Numbers.

* * * * *

(h) * * *

(1) Except as provided in paragraphs (h)(2) and (3) of this section, if the

processing entity determines that the assistance applicant is otherwise eligible to participate in a program, the assistance applicant may retain its place on the waiting list for the program but cannot become a participant until it can provide the documentation referred to in paragraph (g)(1) of this section to verify the SSN of each member of the household.

* * * * *

(3) If a child under the age of 6 years was added to the assistance applicant household within the 6-month period prior to the household's date of admission (or, for the HCV program, the date of voucher issuance), the assistance applicant may become a participant, so long as the documentation required in paragraph (g)(1) of this section is provided to the processing entity within 90 calendar days from the date of admission into the program (or, for the HCV program, the effective date of the Housing Assistance Payment contract). The processing entity must grant an extension of one additional 90-day period if the processing entity determines that, in its discretion, the assistance applicant's failure to comply was due to circumstances that could not reasonably have been foreseen and were outside the control of the assistance applicant. If the applicant family fails to produce the documentation required in paragraph (g)(1) of this section within the required time period, the processing entity must follow the provisions of § 5.218.

* * * * *

■ 3. Amend § 5.520 as follows:

■ a. Revise paragraph (c)(1) introductory text;

■ b. In paragraph (c)(1)(v), remove the comma;

■ c. Revise paragraph (c)(2) introductory text;

■ d. In paragraphs (c)(2)(ii) introductory text and (c)(2)(iii), remove the comma;

■ e. Revise paragraph (d); and

■ f. Add paragraph (e).

The revisions and addition read as follows:

§ 5.520 Proration of assistance.

* * * * *

(c) * * *

(1) *Section 8 assistance other than assistance provided for a tenancy under the Section 8 Housing Choice Voucher Program.* For Section 8 assistance other than assistance for a tenancy under the voucher program, the PHA must prorate the family's assistance as follows:

* * * * *

(2) *Assistance for a Section 8 voucher tenancy.* For a tenancy under the voucher program, the PHA must prorate the family's assistance as follows:

* * * * *

(d) *Method of prorating assistance for Public Housing covered programs.* (1) The PHA must prorate the family's assistance as follows:

(i) *Step 1.* Determine the total tenant payment in accordance with section 5.628. (Annual income includes income of all family members, including any family member who has not established eligible immigration status.)

(ii) *Step 2.* Subtract the total tenant payment from the PHA-established flat rent applicable to the unit. The result is the maximum subsidy for which the family could qualify if all members were eligible (''family maximum subsidy'').

(iii) *Step 3.* Divide the family maximum subsidy by the number of persons in the family (all persons) to determine the maximum subsidy per each family member who has citizenship or eligible immigration status (''eligible family member''). The subsidy per eligible family member is the ''member maximum subsidy.''

(iv) *Step 4.* Multiply the member maximum subsidy by the number of family members who have citizenship or eligible immigration status (''eligible family members'').

(2) The product of steps 1 through 4 of paragraphs (d)(1)(i) through (iv) of this section is the amount of subsidy for which the family is eligible (''eligible subsidy''). The family's rent is the PHA-established flat rent minus the amount of the eligible subsidy.

(e) *Method of prorating assistance when the mixed family's total tenant payment (TTP) is greater than the public housing flat rent.* When the mixed family's TTP is greater than the flat rent, the PHA must use the TTP as the mixed family TTP. The PHA subtracts from the mixed family TTP any established utility allowance, and the sum becomes the mixed family rent.

■ 4. In § 5.603(b), revise the definitions of ''Extremely low income family'' and ''Total tenant payment'' to read as follows:

§ 5.603 Definitions.

* * * * *

(b) * * *

Extremely low-income family. A very low-income family whose annual income does not exceed the higher of:

(1) The poverty guidelines established by the Department of Health and Human Services applicable to the family of the size involved (except in the case of families living in Puerto Rico or any other territory or possession of the United States); or

(2) Thirty (30) percent of the median income for the area, as determined by HUD, with adjustments for smaller and larger families, except that HUD may establish income ceilings higher or lower than 30 percent of the area median income for the area if HUD finds that such variations are necessary because of unusually high or low family incomes.

* * * * *

Total tenant payment. See § 5.628.

* * * * *

§ 5.609 [Amended]

■ 5. Amend § 5.609(b)(9) by adding the phrase ''and any other required fees and charges'' after ''tuition'' in the first sentence.

■ 6. Amend § 5.617 as follows:

■ a. Revise paragraph (a);

■ b. In paragraph (b), add the definition of ''baseline income'' in alphabetical order; and

■ c. Revise paragraph (c) to read as follows:

§ 5.617 Self-sufficiency incentives for persons with disabilities—Disallowance of increase in annual income.

(a) *Applicable programs.* The disallowance of earned income provided by this section is applicable only to the following programs: HOME Investment Partnerships Program (24 CFR part 92); Housing Opportunities for Persons with AIDS (24 CFR part 574); Supportive Housing Program (24 CFR part 583); and the Housing Choice Voucher Program (24 CFR part 982).

(b) * * *

Baseline income. The annual income immediately prior to implementation of the disallowance described in paragraph (c)(1) of this section of a person with disabilities (who is a member of a qualified family).

* * * * *

(c) *Disallowance of increase in annual income*—(1) *Initial 12-month exclusion.* During the 12-month period beginning on the date a member who is a person with disabilities of a qualified family is first employed or the family first experiences an increase in annual income attributable to employment, the responsible entity must exclude from annual income (as defined in the regulations governing the applicable program listed in paragraph (a) of this section) of a qualified family any increase in income of the family member who is a person with disabilities as a result of employment over prior income of that family member.

(2) *Second 12-month exclusion and phase-in.* Upon the expiration of the 12-

month period defined in paragraph (c)(1) of this section and for the subsequent 12-month period, the responsible entity must exclude from annual income of a qualified family at least 50 percent of any increase in income of such family member as a result of employment over the family member's baseline income.

(3) *Maximum 2-year disallowance.* The disallowance of increased income of an individual family member who is a person with disabilities as provided in paragraph (c)(1) or (c)(2) of this section is limited to a lifetime 24-month period. The disallowance applies for a maximum of 12 months for disallowance under paragraph (c)(1) of this section and a maximum of 12 months for disallowance under paragraph (c)(2) of this section, during the 24- month period starting from the initial exclusion under paragraph (c)(1) of this section.

(4) *Effect of changes on currently participating families.* Families eligible for and participating in the disallowance of earned income under this section prior to *May 9, 2016* will continue to be governed by this section in effect as it existed immediately prior to that date (see 24 CFR parts 0 to 199, revised as of April 1, 2016).

* * * * *

■ 7. In § 5.657, add paragraph (d) to read as follows:

§ 5.657 Section 8 project-based assistance programs: Reexamination of family income and composition.

* * * * *

(d) *Streamlined income determination.* For any family member with a fixed source of income, an owner may elect to determine that family member's income, as required by paragraph (b) of this section, by means of a streamlined income determination. A streamlined income determination must be conducted by applying, for each fixed-income source, the verified cost of living adjustment (COLA) or current rate of interest to the previously verified or adjusted income amount.

(1) ''Family member with a fixed source of income'' is defined as a family member whose income includes periodic payments at reasonably predictable levels from one or more of the following sources:

(i) Social Security, Supplemental Security Income, Supplemental Disability Insurance;

(ii) Federal, state, local, or private pension plans;

(iii) Annuities or other retirement benefit programs, insurance policies, disability or death benefits, or other similar types of periodic receipts; or

(iv) Any other source of income subject to adjustment by a verifiable COLA or current rate of interest.

(2) An owner must use a COLA or current rate of interest specific to the fixed source of income in order to adjust the income amount. The owner must verify the appropriate COLA or current rate of interest from a public source or through tenant-provided, third party–generated documentation. If no such verification is available, then the owner must obtain third-party verification of income amounts in order to calculate the change in income for the source.

(3) For any family member whose income is determined pursuant to a streamlined income determination, an owner must obtain third-party verification of all fixed-income amounts every 3 years. Other income for each family member must be determined pursuant to paragraph (b) of this section.

PART 880—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM FOR NEW CONSTRUCTION

■ 8. The authority citation for part 880 continues to read as follows:

Authority: 42 U.S.C. 1437a, 1437c, 1437f, 3535(d), 12701, and 13611–13619.

■ 9. In § 880.603, add paragraph (c)(4) to read as follows:

§ 880.603 Selection and admission of assisted tenants.

* * * * *

(c) * * *

(4) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

PART 884—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM, NEW CONSTRUCTION SET-ASIDE FOR SECTION 515 RURAL RENTAL HOUSING PROJECTS

■ 10. The authority citation for part 884 continues to read as follows:

Authority: 42 U.S.C. 1437a, 1437c, 1437f, 3535(d), and 13611–13619.

■ 11. In § 884.218, add paragraph (d) to read as follows:

§ 884.218 Reexamination of family income and composition.

* * * * *

(d) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

PART 886—SECTION 8 HOUSING ASSISTANCE PAYMENTS PROGRAM—SPECIAL ALLOCATIONS

■ 12. The authority citation for part 886 continues to read as follows:

Authority: 42 U.S.C. 1437a, 1437c, 1437f, 3535(d), and 13611–13619.

■ 13. In § 886.124, add paragraph (d) to read as follows:

§ 886.124 Reexamination of family income and composition.

* * * * *

(d) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

■ 14. In § 886.324, add paragraph (d) to read as follows:

§ 886.324 Reexamination of family income and composition.

* * * * *

(d) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

PART 891—SUPPORTIVE HOUSING FOR THE ELDERLY AND PERSONS WITH DISABILITIES

■ 15. The authority citation for part 891 continues to read as follows:

Authority: 12 U.S.C. 1701q; 42 U.S.C. 1437f, 3535(d), and 8013.

■ 16. In § 891.410, add paragraph (g)(4) to read as follows:

§ 891.410 Selection and admission of tenants.

* * * * *

(g) * * *

(4) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

■ 17. In § 891.610, add paragraph (g)(4) to read as follows:

§ 891.610 Selection and admission of tenants.

* * * * *

(g) * * *

(4) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

■ 18. In § 891.750, add paragraph (c)(4) to read as follows:

§ 891.750 Selection and admission of tenants.

* * * * *

(c) * * *

(4) *Streamlined income determination.* An owner may elect to follow the provisions of 24 CFR 5.657(d).

PART 903—PUBLIC HOUSING AGENCY PLANS

■ 19. The authority citation for part 903 continues to read as follows:

Authority: 2 U.S.C. 1437c; 42 U.S.C. 1437c–1; Pub. L. 110–289; 42 U.S.C. 3535d.

■ 20. In § 903.7, revise paragraph (a)(1)(i) to read as follows:

§ 903.7 What information must a PHA provide in the Annual Plan?

* * * * *

(a) * * *

(1) * * *

(i) Families meeting the definition of extremely low-income families in 24 CFR 5.603.

* * * * *

PART 960—ADMISSION TO, AND OCCUPANCY OF, PUBLIC HOUSING

■ 21. The authority citation for part 960 continues to read as follows:

Authority: 42 U.S.C. 1437a, 1437c, 1437d, 1437n, 1437z–3, and 3535(d).

■ 22. In § 960.102, revise paragraph (a) to read as follows:

§ 960.102 Definitions.

(a) Definitions found elsewhere:

(1) *General definitions.* The following terms are defined in 24 CFR part 5, subpart A: 1937 Act, drug, drug-related criminal activity, elderly person, federally assisted housing, guest, household, HUD, MSA, premises, public housing, public housing agency (PHA), Section 8, violent criminal activity.

(2) *Definitions under the 1937 Act.* The following terms are defined in 24 CFR part 5, subpart D: annual contributions contract (ACC), applicant, elderly family, family, person with disabilities.

(3) *Definitions and explanations concerning income and rent.* The following terms are defined or explained in 24 CFR part 5, subpart F (§ 5.603): Annual income, economic self-sufficiency program, extremely low-income family, low-income family, tenant rent, total tenant payment, utility allowance.

* * * * *

■ 23. Amend § 960.253 as follows:

■ a. Revise paragraph (b);

■ b. In paragraph (c)(1), remove the phrase ''PHA's rent policies'' and add in its place ''PHA's policies'';

■ c. Remove the last sentence of paragraph (c)(3) and add paragraph (c)(4);

■ d. Revise paragraphs (d) and (e)(2);

■ e. Redesignate paragraph (f) as paragraph (g); and

■ f. Add a new paragraph (f).

The revisions and addition read as follows:

§ 960.253 Choice of rent.

* * * * *

(b) Flat rent. The flat rent is determined annually, based on the market rental value of the unit as determined by this paragraph (b).

(1) The PHA must establish a flat rent for each public housing unit that is no less than 80 percent of the applicable Fair Market Rent (FMR) as determined under 24 CFR part 888, subpart A; or

(2) HUD may permit a flat rent of no less than 80 percent of an applicable small area FMR (SAFMR) or unadjusted rent, if applicable, as determined by HUD, or any successor determination, that more accurately reflects local market conditions and is based on an applicable market area that is geographically smaller than the applicable market area used in paragraph (b)(1) of this section. If HUD has not determined an applicable SAFMR or unadjusted rent, the PHA must rely on the applicable FMR under paragraph (b)(1) or may apply for an exception flat rent under paragraph (b)(3).

(3) The PHA may request, and HUD may approve, on a case-by-case basis, a flat rent that is lower than the amounts in paragraphs (b)(1) and (2) of this section, subject to the following requirements:

(i) The PHA must submit a market analysis of the applicable market.

(ii) The PHA must demonstrate, based on the market analysis, that the proposed flat rent is a reasonable rent in comparison to rent for other comparable unassisted units, based on the location, quality, size, unit type, and age of the public housing unit and any amenities, housing services, maintenance, and utilities to be provided by the PHA in accordance with the lease.

(iii) All requests for exception flat rents under this paragraph (b)(3) must be submitted to HUD.

(4) For units where utilities are tenant-paid, the PHA must adjust the flat rent downward by the amount of a utility allowance for which the family might otherwise be eligible under 24 CFR part 965, subpart E.

(5) The PHA must revise, if necessary, the flat rent amount for a unit no later than 90 days after HUD issues new FMRs.

(6) If a new flat rent would cause a family's rent to increase by more than 35 percent, the family's rent increase must be phased in at 35 percent annually until such time that the family chooses to pay the income-based rent or the family is paying the flat rent established pursuant to this paragraph.

(c) * * *

(4) The PHA may elect to establish policies regarding the frequency of utility reimbursement payments for payments made to the family.

(i) The PHA will have the option of making utility reimbursement payments not less than once per calendar-year quarter, for reimbursements totaling $45 or less per quarter. In the event a family leaves the program in advance of its next quarterly reimbursement, the PHA must reimburse the family for a prorated share of the applicable reimbursement. PHAs exercising this option must have a hardship policy in place for tenants.

(ii) If the PHA elects to pay the utility supplier, the PHA must notify the family of the amount of utility reimbursement paid to the utility supplier.

(d) *Ceiling rent.* A PHA using ceiling rents authorized and established before October 1, 1999, may continue to use ceiling rents, provided such ceiling rents are set at the level required for flat rents under this section. PHAs must follow the requirements for calculating and adjusting flat rents in paragraph (b) of this section when calculating and adjusting ceiling rents.

(e) * * *

(2) The dollar amounts of tenant rent for the family under each option, following the procedures in paragraph (f) of this section.

(f) *Choice between flat and income-based rents.* Families must be offered the choice between a flat rental amount and a previously calculated income-based rent according to the following:

(1) For a family that chooses the flat rent option, the PHA must conduct a reexamination of family income and composition at least once every three years.

(2) At initial occupancy, or in any year in which a participating family is paying the income-based rent, the PHA must:

(i) Conduct a full examination of family income and composition, following the provisions in § 960.257;

(ii) Inform the family of the flat rental amount and the income-based rental amount determined by the examination of family income and composition;

(iii) Inform the family of the PHA's policies on switching rent types in circumstances of financial hardship; and

(iv) Apply the family's rent decision at the next lease renewal.

(3) In any year in which a family chooses the flat rent option but the PHA chooses not to conduct a full examination of family income and

composition for the annual rent option under the authority of paragraph (f)(1) of this section, the PHA must:

(i) Use income information from the examination of family income and composition from the first annual rent option;

(ii) Inform the family of the updated flat rental amount and the rental amount determined by the most recent examination of family income and composition;

(iii) Inform the family of the PHA's policies on switching rent types in circumstances of financial hardship; and

(iv) Apply the family's rent decision at the next lease renewal.

* * * * *

■ 24. Amend § 960.255 as follows:

■ a. In paragraph (a), add the definition of ''baseline income'' in alphabetical order; and

■ b. Revise paragraph (b) to read as follows:

§ 960.255 Self-sufficiency incentives—Disallowance of increase in annual income.

(a) * * *

Baseline income. The annual income immediately prior to implementation of the disallowance described in paragraph (c)(1) of this section of a person who is a member of a qualified family.

* * * * *

(b) *Disallowance of earned income*—(1) *Initial 12-month exclusion.* During the 12-month period beginning on the date on which a member of a qualified family is first employed or the family first experiences an increase in annual income attributable to employment, the PHA must exclude from the annual income (as defined in § 5.609 of this title) of a qualified family any increase in the income of the family member as a result of employment over the baseline income of that family member.

(2) *Phase-in of rent increase.* Upon the expiration of the 12-month period defined in paragraph (b)(1) of this section and for the subsequent 12-month period, the PHA must exclude from the annual income of a qualified family at least 50 percent of any increase in income of such family member as a result of employment over the family member's baseline income.

(3) *Maximum 2-year disallowance.* The disallowance of increased income of an individual family member as provided in paragraph (b)(1) or (b)(2) of this section is limited to a lifetime 24-month period. It applies for a maximum of 12 months for disallowance under paragraph (b)(1) of this section and a maximum of 12 months for disallowance under paragraph (b)(2) of this section, during the 24-month period starting from the initial exclusion under paragraph (b)(1) of this section.

(4) Effect of changes on currently participating families. Families eligible for and participating in the disallowance of earned income under this section prior to May 9, 2016 will continue to be governed by this section in effect as it existed immediately prior to that date.

* * * * *

■ 25. In § 960.257, revise the section heading and paragraphs (a)(2) and (b) to read as follows:

§ 960.257 Family income and composition: Annual and interim reexaminations.

(a) * * *

(2) For families who choose flat rents, the PHA must conduct a reexamination of family composition at least annually, and must conduct a reexamination of family income at least once every three years in accordance with the procedures in § 960.253(f).

* * * * *

(b) *Interim reexaminations.* (1) A family may request an interim reexamination of family income or composition because of any changes since the last determination.

(2) The PHA must make the interim reexamination within a reasonable time after the family request. The PHA must adopt policies prescribing when and under what conditions the family must report a change in family income or composition.

(3) Streamlined income determination. For any family member with a fixed source of income, a PHA may elect to determine that family member's income by means of a streamlined income determination. A streamlined income determination must be conducted by applying, for each fixed-income source, the verified cost of living adjustment (COLA) or current rate of interest to the previously verified or adjusted income amount.

(i) ''Family member with a fixed source of income'' is defined as a family member whose income includes periodic payments at reasonably predictable levels from one or more of the following sources:

(A) Social Security, Supplemental Security Income, Supplemental Disability Insurance;

(B) Federal, state, local, or private pension plans;

(C) Annuities or other retirement benefit programs, insurance policies, disability or death benefits, or other similar types of periodic receipts; or

(D) Any other source of income subject to adjustment by a verifiable COLA or current rate of interest.

(ii) A PHA must use a COLA or current rate of interest specific to the fixed source of income in order to adjust the income amount. The PHA must verify the appropriate COLA or current rate of interest from a public source or through tenant-provided, third party–generated documentation. If no such verification is available, then the PHA must obtain third-party verification of income amounts in order to calculate the change in income for the source.

(iii) For any family member whose income is determined pursuant to a streamlined income determination, a PHA must obtain third-party verification of all income amounts every 3 years.

* * * * *

■ 26. In § 960.259, revise paragraph (c)(1) introductory text, and add paragraph (c)(2) to read as follows:

§ 960.259 Family information and verification.

* * * * *

(c) * * *

(1) Except as provided in paragraph (c)(2) of this section, the PHA must obtain and document in the family file third-party verification of the following factors, or must document in the file why third-party verification was not available:

* * * * *

(2) For a family with net assets equal to or less than $5,000, a PHA may accept, for purposes of recertification of income, a family's declaration that it has net assets equal to or less than $5,000, without taking additional steps to verify the accuracy of the declaration.

(i) The declaration must state the amount of income the family expects to receive from such assets; this amount must be included in the family's income.

(ii) A PHA must obtain third-party verification of all family assets every 3 years.

■ 27. In § 960.605, revise paragraphs (c)(2) through (5) to read as follows:

§ 960.605 How PHA administers service requirements.

* * * * *

(c) * * *

(2) The PHA must give the family a written description of the service requirement, and of the process for claiming status as an exempt person and for PHA verification of such status. The PHA must also notify the family of its determination identifying the family members who are subject to the service requirement, and the family members who are exempt persons. The PHA must also notify the family that it will be

validating a sample of self-certifications of completion of the service requirement accepted by the PHA under § 960.607(a)(1)(ii).

(3) The PHA must review family compliance with service requirements and must verify such compliance annually at least 30 days before the end of the 12-month lease term. If qualifying activities are administered by an organization other than the PHA, the PHA may obtain verification of family compliance from such third parties or may accept a signed certification from the family member that he or she has performed such qualifying activities.

(4) The PHA must retain reasonable documentation of service requirement performance or exemption in a participant family's files.

(5) The PHA must comply with non-discrimination and equal opportunity requirements listed at § 5.105(a) of this title and affirmatively further fair housing in all their activities in accordance with the AFFH Certification as described in § 903.7(o) of this chapter.

■ 28. In § 960.607, revise paragraph (a) to read as follows:

§ 960.607 Assuring resident compliance.

(a) *Acceptable documentation demonstrating compliance.* (1) If qualifying activities are administered by an organization other than the PHA, a family member who is required to fulfill a service requirement must provide one of the following:

(i) A signed certification to the PHA by such other organization that the family member has performed such qualifying activities; or

(ii) A signed self-certification to the PHA by the family member that he or she has performed such qualifying activities.

(2) The signed self-certification must include the following:

(i) A statement that the tenant contributed at least 8 hours per month of community service not including political activities within the community in which the adult resides; or participated in an economic self-sufficiency program (as that term is defined in 24 CFR 5.603(b)) for at least 8 hours per month;

(ii) The name, address, and a contact person at the community service provider; or the name, address, and contact person for the economic self-sufficiency program;

(iii) The date(s) during which the tenant completed the community service activity, or participated in the economic self-sufficiency program;

(iv) A description of the activity completed; and

(v) A certification that the tenant's statement is true.

(3) If a PHA accepts self-certifications under paragraph (a)(1)(ii) of this section, the PHA must validate a sample of such self-certifications using third-party certification described in paragraph (a)(1)(i) of this section.

* * * * *

PART 966—PUBLIC HOUSING LEASE AND GRIEVANCE PROCEDURE

■ 29. The authority citation for part 966 continues to read as follows:

Authority: 42 U.S.C. 1437d and 3535(d).

■ 30. Revise § 966.4(n) to read as follows:

§ 966.4 Lease requirements.

* * * * *

(n) *Grievance procedures.* (1) The lease must provide that all disputes concerning the obligations of the tenant or the PHA must (except as provided in § 966.51(a)(2)) be resolved in accordance with the PHA grievance procedures. The grievance procedures must comply with subpart B of this part.

(2) The lease must include a description of the PHA's policies for selecting a hearing officer.

* * * * *

■ 31. Amend § 966.52 by adding a sentence at the end of paragraph (a) and adding paragraph (e), to read as follows:

§ 966.52 Requirements.

(a) * * * A PHA may establish an expedited grievance procedure as defined in § 966.53.

* * * * *

(e) The PHA must not only meet the minimal procedural due process requirements contained in this subpart but also satisfy any additional requirements required by local, state, or federal law.

■ 32. In § 966.53, revise paragraphs (b), (d), and (e) to read as follows:

§ 966.53 Definitions.

* * * * *

(b) *Complainant* shall mean any tenant whose grievance is presented to the PHA or at the project management office.

* * * * *

(d) *Expedited grievance* means a procedure established by the PHA for any grievance concerning a termination of tenancy or eviction that involves:

(1) Any criminal activity that threatens the health, safety, or right to peaceful enjoyment of the PHA's public housing premises by other residents or employees of the PHA; or

(2) Any drug-related or violent criminal activity on or off such premises.

(e) *Hearing officer* means an impartial person or persons selected by the PHA, other than the person who made or approved the decision under review, or a subordinate of that person. Such individual or individuals do not need legal training. PHAs must describe their policies for selection of a hearing officer in their lease forms as required by § 966.4, changes to which are subject to a 30-day comment period as described in § 966.3.

* * * * *

§ 966.54 [Amended]

■ 33. Amend § 966.54 by removing the phrase ''under § 966.55''.

§ 966.55 [Removed]

■ 34. Remove § 966.55.

■ 35. Amend § 966.56 as follows:

■ a. Revise paragraph (a);

■ b. In paragraph (b)(2), remove the comma;

■ c. Remove paragraphs (c) and (f);

■ d. Redesignate paragraphs (d), (e), (g), and (h) as paragraphs (c), (d), (e) and (f), respectively;

■ e. Revise redesignated paragraph (c); and

■ f. Add paragraph (g).

The revisions and addition read as follows:

§ 966.56 Procedures governing the hearing.

(a) The hearing must be scheduled promptly for a time and place reasonably convenient to both the complainant and the PHA and held before a hearing officer. A written notification specifying the time, place, and the procedures governing the hearing must be delivered to the complainant and the appropriate official.

* * * * *

(c) If the complainant or the PHA fails to appear at a scheduled hearing, the hearing officer may make a determination to postpone the hearing for no more than 5 business days or may make a determination that the party has waived his right to a hearing. Both the complainant and the PHA must be notified of the determination by the hearing officer. A determination that the complainant has waived the complainant's right to a hearing will not constitute a waiver of any right the complainant may have to contest the PHA's disposition of the grievance in an appropriate judicial proceeding.

* * * * *

(g) *Limited English Proficiency.* PHAs must comply with HUD's ''Final

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons'' issued on January 22, 2007 and available at *http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/promotingfh/lep-faq.*

■ 36. Revise § 966.57 to read as follows:

§ 966.57 Decision of the hearing officer.

(a) The hearing officer must prepare a written decision, including the reasons for the PHA's decision within a reasonable time after the hearing. A copy of the decision must be sent to the complainant and the PHA. The PHA must retain a copy of the decision in the tenant's folder. The PHA must maintain a log of all hearing officer decisions and make that log available upon request of the hearing officer, a prospective complainant, or a prospective complainant's representative.

(b) The decision of the hearing officer will be binding on the PHA unless the PHA Board of Commissioners determines that:

(1) The grievance does not concern PHA action or failure to act in accordance with or involving the complainant's lease on PHA regulations, which adversely affects the complainant's rights, duties, welfare or status; or

(2) The decision of the hearing officer is contrary to applicable Federal, State or local law, HUD regulations or requirements of the annual contributions contract between HUD and the PHA.

(c) A decision by the hearing officer or Board of Commissioners in favor of the PHA or which denies the relief requested by the complainant in whole or in part will not constitute a waiver of, nor affect in any manner whatever, any rights the complainant may have to a trial de novo or judicial review in any judicial proceedings, which may thereafter be brought in the matter.

PART 982—SECTION 8 TENANT-BASED ASSISTANCE: HOUSING CHOICE VOUCHER PROGRAM

■ 37. The authority citation for part 982 continues to read as follows:

Authority: 42 U.S.C. 1437f and 3535(d).

■ 38. In § 982.402 add a sentence at the end of paragraph (d)(2) to read as follows:

§ 982.402 Subsidy standards.

* * * * *

(d) * * *

(2) * * * However, utility allowances must follow § 982.517(d).

■ 39. Amend § 982.405 as follows:

■ a. In paragraph (a), remove the word ''annually'' and add in its place ''biennially'';

■ b. Revise paragraph (e); and

■ c. Add paragraphs (f) and (g).

The revision and addition read as follows:

§ 982.405 PHA initial and periodic unit inspection.

* * * * *

(e) The PHA may not charge the family for an initial inspection or reinspection of the unit.

(f) The PHA may not charge the owner for the inspection of the unit prior to the initial term of the lease or for a first inspection during assisted occupancy of the unit. The PHA may establish a reasonable fee to owners for a reinspection if an owner notifies the PHA that a repair has been made or the allotted time for repairs has elapsed and a reinspection reveals that any deficiency cited in the previous inspection that the owner is responsible for repairing pursuant to § 982.404(a) was not corrected. The owner may not pass this fee along to the family. Fees collected under this paragraph will be included in a PHA's administrative fee reserve and may be used only for activities related to the provision of Section 8 Tenant-Based Rental Assistance.

(g) If a participant family or government official reports a condition that is life-threatening (*i.e.,* the PHA would require the owner to make the repair within no more than 24 hours in accordance with § 982.404(a)(3)), then the PHA must inspect the housing unit within 24 hours of when the PHA received the notification. If the reported condition is not life-threatening (*i.e.,* the PHA would require the owner to make the repair within no more than 30 calendar days in accordance with § 982.404(a)(3)), then the PHA must inspect the unit within 15 days of when the PHA received the notification. In the event of extraordinary circumstances, such as if a unit is within a Presidentially declared disaster area, HUD may waive the 24-hour or the 15-day inspection requirement until such time as an inspection is feasible.

§ 982.406 [Redesignated as § 982.407]

■ 40. Redesignate § 982.406 as § 982.407.

■ 41. Add a new § 982.406 to read as follows:

§ 982.406 Use of alternative inspections.

(a) *In general.* (1) A PHA may comply with the inspection requirement in § 982.405(a) by relying on an alternative inspection (*i.e.,* an inspection conducted for another housing assistance program) only if the PHA is able to obtain the results of the alternative inspection.

(2) If an alternative inspection method employs sampling, then a PHA may rely on such alternative inspection method to comply with the requirement in § 982.405(a) only if HCV units are included in the population of units forming the basis of the sample.

(3) Units in properties that are mixed-finance properties assisted with project-based vouchers may be inspected at least triennially pursuant to 24 CFR 983.103(g).

(b) *Administrative plans.* A PHA relying on an alternative inspection to fulfill the requirement in § 982.405(a) must identify the alternative inspection method being used in the PHA's administrative plan. Such a change may be a significant amendment to the plan, in which case the PHA must follow its plan amendment and public notice requirements, in addition to meeting the requirements in § 982.406(c)(2), if applicable, before using the alternative inspection method.

(c) *Eligible inspection methods.* (1) A PHA may rely upon inspections of housing assisted under the HOME Investment Partnerships (HOME) program or housing financed using Low-Income Housing Tax Credits (LIHTCs), or inspections performed by HUD, with no action other than amending its administrative plan.

(2) If a PHA wishes to rely on an inspection method other than a method listed in paragraph (c)(1) of this section, then, prior to amending its administrative plan, the PHA must submit to the Real Estate Assessment Center (REAC) a copy of the inspection method it wishes to use, along with its analysis of the inspection method that shows that the method ''provides the same or greater protection to occupants of dwelling units'' as would HQS.

(i) A PHA may rely upon such alternative inspection method only upon receiving approval from REAC to do so.

(ii) A PHA that uses an alternative inspection method approved under this paragraph must monitor changes to the standards and requirements applicable to such method. If any change is made to the alternative inspection method, then the PHA must submit to REAC a copy of the revised standards and requirements, along with a revised comparison to HQS. If the PHA or REAC

determines that the revision would cause the alternative inspection to no longer meet or exceed HQS, then the PHA may no longer rely upon the alternative inspection method to comply with the inspection requirement at § 982.405(a).

(d) *Results of alternative inspection.* (1) In order for a PHA to rely upon the results of an alternative inspection to comply with the requirement at § 982.405(a), a property inspected pursuant to such method must meet the standards or requirements regarding housing quality or safety applicable to properties assisted under the program using the alternative inspection method. To make the determination of whether such standards or requirements are met, the PHA must adhere to the following procedures:

(i) If a property is inspected under an alternative inspection method, and the property receives a ''pass'' score, then the PHA may rely on that inspection to demonstrate compliance with the inspection requirement at § 982.405(a).

(ii) If a property is inspected under an alternative inspection method, and the property receives a ''fail'' score, then the PHA may not rely on that inspection to demonstrate compliance with the inspection requirement at § 982.405(a).

(iii) If a property is inspected under an alternative inspection method that does not employ a pass/fail determination—for example, in the case of a program where deficiencies are simply identified—then the PHA must review the list of deficiencies to determine whether any cited deficiency would have resulted in a ''fail'' score under HQS. If no such deficiency exists, then the PHA may rely on the inspection to demonstrate compliance with the inspection requirement at § 982.405(a); if such a deficiency does exist, then the PHA may not rely on the inspection to demonstrate such compliance.

(2) Under any circumstance described above in which a PHA is prohibited from relying on an alternative inspection method for a property, the PHA must, within a reasonable period of time, conduct an HQS inspection of any units in the property occupied by voucher program participants and follow HQS procedures to remedy any identified deficiencies.

(e) *Records retention.* As with all other inspection reports, and as required by § 982.158(f)(4), reports for inspections conducted pursuant to an alternative inspection method must be obtained by the PHA. Such reports must be available for HUD inspection for at least three years from the date of the latest inspection.

■ 42. Amend § 982.503 as follows:

■ a. Add paragraph (b)(1)(iii);

■ b. Remove the first word in paragraph (b)(2) and in its place add ''Except as described in paragraph (b)(1)(iii) of this section, the''; and

■ c. Revise paragraph (c)(2).

The revision and addition read as follows:

§ 982.503 Payment standard amount and schedule.

* * * * *

(b) * * *

(1) * * *

(iii) The PHA may establish an exception payment standard of not more than 120 percent of the published FMR if required as a reasonable accommodation in accordance with 24 CFR part 8 for a family that includes a person with a disability. Any unit approved under an exception payment standard must still meet the reasonable rent requirements found at § 982.507.

* * * * *

(c) * * *

(2) *Above 110 percent of FMR to 120 percent of published FMR.* The HUD Field Office may approve an exception payment standard amount from above 110 percent of the published FMR to not more than 120 percent of the published FMR (upper range) if the HUD Field Office determines that approval is justified by either the median rent method or the 40th or 50th percentile rent method as described in paragraph (c)(2)(ii) of this section (and that such approval is also supported by an appropriate program justification in accordance with paragraph (c)(4) of this section).

(i) *Median rent method.* In the median rent method, HUD determines the exception payment standard amount by multiplying the FMR times a fraction of which the numerator is the median gross rent of the exception area and the denominator is the median gross rent of the entire FMR area. In this method, HUD uses median gross rent data from the most recent decennial United States census, and the exception area may be any geographic entity within the FMR area (or any combination of such entities) for which median gross rent data is provided in decennial census products.

(ii) *40th or 50th percentile rent method.* In this method, HUD determines that the area exception payment standard amount equals either the 40th or 50th percentile of rents for standard quality rental housing in the exception area. HUD determines whether the 40th or 50th percentile rent applies in accordance with the methodology described in § 888.113 of this title for determining FMRs. A PHA must present statistically representative rental housing survey data to justify HUD approval.

* * * * *

■ 43. Revise § 982.505(d) to read as follows:

§ 982.505 How to calculate housing assistance payment.

* * * * *

(d) *PHA approval of higher payment standard for the family as a reasonable accommodation.* If the family includes a person with disabilities and requires a payment standard above the basic range, as a reasonable accommodation for such person, in accordance with part 8 of this title, the PHA may establish a payment standard for the family of not more than 120 percent of the FMR.

■ 44. In § 982.514, add paragraph (c) to read as follows:

§ 982.514 Distribution of housing assistance payment.

* * * * *

(c) The PHA may elect to establish policies regarding the frequency of utility reimbursement payments for payments made to the family.

(1) The PHA will have the option of making utility reimbursement payments not less than once per calendar-year quarter, for reimbursements totaling $45 or less per quarter. In the event a family leaves the program in advance of its next quarterly reimbursement, the PHA would be required to reimburse the family for a prorated share of the applicable reimbursement. PHAs exercising this option must have a hardship policy in place for tenants.

(2) If the PHA elects to pay the utility supplier directly, the PHA must notify the family of the amount paid to the utility supplier.

■ 45. Amend § 982.516 as follows:

■ a. Revise the section heading;

■ b. In paragraph (a), revise the introductory text of paragraph (a)(2) and add paragraph (a)(3);

■ c. Remove paragraph (e);

■ d. Redesignate paragraphs (b), (c), and (d) as paragraphs (c), (d), and (e), respectively;

■ e. Add a new paragraph (b);

■ f. In redesignated paragraph (c), revise the paragraph heading; and

■ g. Revise redesignated paragraph (e)(2).

The revisions and addition read as follows:

§ 982.516 Family income and composition: Annual and interim examinations.

(a) * * *

(2) Except as provided in paragraph (a)(3) of this section, the PHA must

obtain and document in the tenant file third-party verification of the following factors, or must document in the tenant file why third-party verification was not available:

* * * * *

(3) For a family with net assets equal to or less than $5,000, a PHA may accept a family's declaration that it has net assets equal to or less than $5,000, without taking additional steps to verify the accuracy of the declaration.

(i) The declaration must state the amount of income the family expects to receive from such assets; this amount must be included in the family's income.

(ii) A PHA must obtain third-party verification of all family assets every 3 years.

(b) *Streamlined income determination.* For any family member with a fixed source of income, a PHA may elect to determine that family member's income by means of a streamlined income determination. A streamlined income determination must be conducted by applying, for each fixed-income source, the verified cost of living adjustment (COLA) or current rate of interest to the previously verified or adjusted income amount.

(1) *Family member with a fixed source of income* is defined as a family member whose income includes periodic payments at reasonably predictable levels from one or more of the following sources:

(i) Social Security, Supplemental Security Income, Supplemental Disability Insurance;

(ii) Federal, state, local, or private pension plans;

(iii) Annuities or other retirement benefit programs, insurance policies, disability or death benefits, or other similar types of periodic receipts; or

(iv) Any other source of income subject to adjustment by a verifiable COLA or current rate of interest.

(2) A PHA must use a COLA or current rate of interest specific to the fixed source of income in order to adjust the income amount. The PHA must verify the appropriate COLA or current rate of interest from a public source or through tenant-provided, third party-generated documentation. If no such verification is available, then the PHA must obtain third-party verification of income amounts in order to calculate the change in income for the source.

(3) For any family member whose income is determined pursuant to a streamlined income determination, a PHA must obtain third-party verification of all income amounts every 3 years.

(c) *Interim reexaminations.* * * *

* * * * *

(e) * * *

(2) At the effective date of a regular or interim reexamination, the PHA must make appropriate adjustments in the housing assistance payment in accordance with § 982.505.

* * * * *

■ 46. Amend § 982.517 as follows:

■ a. Capitalize the first word in paragraph (b)(2)(i); and

■ b. Revise paragraph (d), to read as follows:

§ 982.517 Utility allowance schedule.

* * * * *

(d) *Use of utility allowance schedule.* The PHA must use the appropriate utility allowance for the lesser of the size of dwelling unit actually leased by the family or the family unit size as determined under the PHA subsidy standards. In cases where the unit size leased exceeds the family unit size as determined under the PHA subsidy standards as a result of a reasonable accommodation, the PHA must use the appropriate utility allowance for the size of the dwelling unit actually leased by the family.

* * * * *

PART 983—PROJECT-BASED VOUCHER (PBV) PROGRAM

■ 47. The authority citation for part 983 continues to read as follows:

Authority: 42 U.S.C. 1437f and 3535(d).

§ 983.2 [Amended]

■ 48. In § 983.2 amend paragraph (c)(4) by removing the citation ''§ 982.406'' and adding in its place ''§ 982.407''.

■ 49. Amend § 983.103 by revising paragraph (d) and adding paragraph (g) to read as follows:

§ 983.103 Inspecting units.

* * * * *

(d) *Biennial inspections.* (1) At least biennially during the term of the HAP contract, the PHA must inspect a random sample, consisting of at least 20 percent of the contract units in each building, to determine if the contract units and the premises are maintained in accordance with the HQS. Turnover inspections pursuant to paragraph (c) of this section are not counted toward meeting this inspection requirement.

(2) If more than 20 percent of the sample of inspected contract units in a building fail the initial inspection, then the PHA must reinspect 100 percent of the contract units in the building.

(3) A PHA may also use the procedures applicable to HCV units in 24 CFR 982.406.

* * * * *

(g) *Mixed-finance properties.* In the case of a property assisted with project-based vouchers (authorized at 42 U.S.C. 1437f(o)(13)) that is subject to an alternative inspection, the PHA may rely upon inspections conducted at least triennially to demonstrate compliance with the inspection requirement of 24 CFR 982.405(a).

PART 990—THE PUBLIC HOUSING OPERATING FUND PROGRAM

■ 50. The authority citation for part 990 continues to read as follows:

Authority: 42 U.S.C. 1437g; 42 U.S.C. 3535(d).

■ 51. In § 990.150, revise paragraph (a) to read as follows:

§ 990.150 Limited vacancies.

(a) *Operating subsidy for a limited number of vacancies.* HUD will pay operating subsidy for a limited number of vacant units under an ACC. The limited number of vacant units must be equal to or less than 3 percent of the unit months on a project-by-project basis based on the definition of a project under § 990.265 (provided that the number of eligible unit months does not exceed 100 percent of the unit months for a project).

* * * * *

Dated: February 29, 2016.

Nani Coloretti,

Deputy Secretary.

[FR Doc. 2016–04901 Filed 3–7–16; 8:45 am]

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Part IV

Department of the Interior

Fish and Wildlife Service

Proposed Revisions to the U.S. Fish and Wildlife Service Mitigation Policy; Notice

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[Docket No. FWS–HQ–ES–2015–0126; FXHC11220900000–156–FF09E33000]

Proposed Revisions to the U.S. Fish and Wildlife Service Mitigation Policy

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Announcement of draft policy; request for public comment.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce proposed revisions to our Mitigation Policy, which has guided Service recommendations on mitigating the adverse impacts of land and water developments on fish, wildlife, plants, and their habitats since 1981. The revisions are motivated by changes in conservation challenges and practices since 1981, including accelerating loss of habitats, effects of climate change, and advances in conservation science. The revised policy provides a framework for applying a landscape-scale approach to achieve, through application of the mitigation hierarchy, a net gain in conservation outcomes, or at a minimum, no net loss of resources and their values, services, and functions resulting from proposed actions. The primary intent of the policy is to apply mitigation in a strategic manner that ensures an effective linkage with conservation strategies at appropriate landscape scales. We request comments, information, and recommendations from governmental agencies, Indian Tribes, the scientific community, industry groups, environmental interest groups, and any other interested parties.

DATES: We will accept comments from all interested parties until May 9, 2016. Please note that if you are using the Federal eRulemaking Portal (see **ADDRESSES** below), the deadline for submitting an electronic comment is 11:59 p.m. Eastern Standard Time on this date.

ADDRESSES: *Document Review:* The draft policy is available for review at *http://www.regulations.gov,* under docket number FWS–HQ–ES–2015–0126.

General Comments: You may submit comments by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* In the Search box, enter the Docket number for the proposed policy, which is FWS–HQ–ES–2015–0126. You may enter a comment by clicking on the ''Comment Now!'' button. Please ensure that you have found the correct document before submitting your comment.
- *U.S. mail or hand delivery:* Public Comments Processing, Attn: Docket No. FWS–HQ–ES–2015–0126; Division of Policy, Performance and Management; U.S. Fish and Wildlife Service; 5275 Leesburg Pike, ABHC–PPM; Falls Church, VA 22041–3803.

We will post all comments on *http://www.regulations.gov.* This generally means that we will post any personal information you provide us (see Request for Information below for more information).

FOR FURTHER INFORMATION CONTACT: Jason Miller, U.S. Fish and Wildlife Service, Branch of Conservation Planning Assistance, 5275 Leesburg Pike, Falls Church, VA 22041–3803, telephone 703–358–1756.

SUPPLEMENTARY INFORMATION: We, the U.S. Fish and Wildlife Service (Service), announce proposed revisions to our Mitigation Policy (January 23, 1981; 46 FR 7644–7663), which has guided Service recommendations on mitigating the adverse impacts of land and water developments on fish, wildlife, plants, and their habitats since 1981. The revisions are motivated by changes in conservation challenges and practices since 1981, including accelerating loss of habitats, effects of climate change, and advances in conservation science. The revised policy provides a framework for applying a landscape-scale approach to achieve, through application of the mitigation hierarchy, a net gain in conservation outcomes, or at a minimum, no net loss of resources and their values, services, and functions resulting from proposed actions. The primary intent of the policy is to apply mitigation in a strategic manner that ensures an effective linkage with conservation strategies at appropriate landscape scales.

The revised policy integrates all authorities that allow the Service to recommend or require mitigation of impacts to Federal trust fish and wildlife resources, and other resources identified in statute, during development processes. It is intended to serve as a single umbrella policy under which the Service may issue more detailed policies or guidance documents covering specific activities in the future.

Background

The U.S. Fish and Wildlife Service (Service) is revising its 1981 Mitigation Policy (1981 Policy), which has guided Service recommendations on mitigating the adverse impacts of land and water developments on fish, wildlife, plants, and their habitats, and uses thereof since 1981. The primary intent of the policy is to apply mitigation in a strategic manner that ensures an effective linkage with conservation strategies at appropriate landscape scales, consistent with the Presidential Memorandum on Mitigating Impacts on Natural Resources from Development and Encouraging Related Private Investment (November 3, 2015), the Secretary of the Interior's Order 3330 entitled ''Improving Mitigation Policies and Practices of the Department of the Interior'' (October 31, 2013), and the Departmental Manual Chapter (600 DM 6) on Implementing Mitigation at the Landscape-scale (October 23, 2015). Within this context, our revisions of the 1981 Policy: (a) Broaden its scope to address all resources for which the Service has authorities to recommend or require mitigation for impacts to resources; and (b) provide an updated framework for applying mitigation measures that will maximize their effectiveness at multiple geographic scales.

By memorandum, the President directed all Federal agencies that manage natural resources to avoid and minimize damage to natural resources and to effectively offset remaining impacts, consistent with the principles declared in the memorandum and existing statutory authority. Under the memorandum, all Federal mitigation policies shall clearly set a net benefit goal or, at minimum, a no net loss goal for natural resources, wherever doing so is allowed by existing statutory authority and is consistent with agency mission and established natural resource objectives. The policy proposed herein implements the President's directions for the Service.

Secretarial Order 3330 established a Department-wide mitigation strategy to ensure consistency and efficiency in the review and permitting of infrastructure development projects and in conserving natural and cultural resources. The Order charged the Department's Energy and Climate Change Task Force with developing a report that addresses how to best implement consistent, Department-wide mitigation practices and strategies. The report of the Task Force, ''A Strategy for Improving the Mitigation Policies and Practices of the Department of the Interior'' (April 2014), describes guiding principles for mitigation to improve process efficiency, including the use of landscape-scale approaches rather than project-by-project or single-resource mitigation approaches. This revision of the Service's Mitigation Policy complies with a deliverable identified in the Strategy that seeks to implement the guiding principles set forth in the

Secretary's Order, the corresponding Strategy, and subsequent 600 DM 6.

In 600 DM 6, the Department of the Interior established policy intended to improve permitting processes and help achieve beneficial outcomes for project proponents, impacted communities, and the environment. By implementing this Manual Chapter, the Department will:

(a) Effectively mitigate impacts to Department-managed resources and their values, services, and functions;

(b) provide project developers with added predictability and efficient and timely environmental reviews;

(c) improve the resilience of resources in the face of climate change;

(d) encourage strategic conservation investments in lands and other resources; increase compensatory mitigation effectiveness, durability, transparency, and consistency; and

(e) better utilize mitigation measures to help achieve Departmental goals.

The policy proposed herein implements the Department's directions for the Service.

As with the 1981 Policy, the Service intends, with this revision, to conserve, protect, and enhance fish, wildlife, plants, and their habitats for future generations. Effective mitigation is a powerful tool for furthering this mission.

Discussion

The Service's motivations for revising the 1981 Policy include:

- Accelerating loss, including degradation and fragmentation, of habitats and subsequent loss of ecosystem function since 1981;
- Threats that were not fully evident in 1981, such as effects of climate change, the spread of invasive species, and outbreaks of epizootic diseases, are now challenging the Service's conservation mission;
- The science of fish and wildlife conservation has substantially advanced in the past three decades;
- The Federal statutory, regulatory, and policy context of fish and wildlife conservation has substantially changed since the 1981 Policy; and
- A need to clarify the Service's definition and usage of mitigation in various contexts, including the conservation of species listed as threatened or endangered under the Endangered Species Act, which was expressly excluded from the 1981 Policy.

Mitigation Defined

In the context of impacts to environmental resources (including their values, services, and functions) resulting from proposed actions, ''mitigation'' is a general label for measures that a proponent takes to avoid, minimize, and compensate for such impacts. The 1981 Policy adopted the definition of mitigation in the Council on Environmental Quality (CEQ) National Environmental Policy Act (NEPA) regulations (40 CFR 1508.20). The CEQ mitigation definition remains unchanged since codification in 1978 and states that ''Mitigation includes:

- Avoiding the impact altogether by not taking a certain action or parts of an action;
- minimizing impacts by limiting the degree or magnitude of the action and its implementation;
- rectifying the impact by repairing, rehabilitating, or restoring the affected environment;
- reducing or eliminating the impact over time by preservation and maintenance operations during the life of the action; and
- compensating for the impact by replacing or providing substitute resources or environments.''

This definition is adopted in this revised policy, and the use of its components in various contexts is clarified. In 600 DM 6, the Department of the Interior states that mitigation, as enumerated by CEQ, is compatible with Departmental policy; however, as a practical matter, the mitigation elements are categorized into three general types that form a sequence: Avoidance, minimization, and compensatory mitigation for remaining unavoidable (also known as residual) impacts. The 1981 Policy further stated that the Service considers the sequence of the CEQ mitigation definition elements to represent the desirable sequence of steps in the mitigation planning process. The Service generally affirms this hierarchical approach in this policy. We advocate first avoiding and then minimizing impacts that critically impair our ability to achieve conservation objectives for affected resources. We also provide guidance that recognizes how action- and resource-specific circumstances may warrant departures from the preferred mitigation sequence; for example, as when impacts to a species may occur at a location that is not critical to achieving the conservation objectives for that species, or when current conditions are likely to change substantially due to the effects of a changing climate. In such circumstances, relying more on compensating for the impacts at another location may more effectively serve the conservation objectives for the affected resources. This policy provides a logical framework for the Service to consistently make such choices.

Scope of the Revised Mitigation Policy

The Service's mission is to conserve, protect, and enhance fish, wildlife, and plants, and their habitats for the continuing benefit of the American people. This mission includes a responsibility to make mitigation recommendations and requirements during the review of actions based on numerous authorities related to specific covered plant and animal species, habitats, and broader ecological functions. Our authority to engage actions that may affect these resources extends to all U.S. States and territories, on public and on private lands. This unique standing necessitates that we clarify our integrated interests and expectations when seeking mitigation for impacts to fish, wildlife, plants, and their habitats.

This policy serves as over-arching Service guidance applicable to all actions for which the Service has specific authority to recommend or require the mitigation of impacts to fish, wildlife, plants, and their habitats. As necessary and as budgetary resources permit, we intend to adapt or develop Service program-specific policies, handbooks, and guidance documents, consistent with the applicable statutes, to integrate the spirit and intent of this policy.

New Threats and New Science

Since the publication of the Service's 1981 Policy, land use changes in the United States have reduced the habitats available to fish and wildlife. By 1982, approximately 71 million acres of the lower 48 States had already been developed. Between 1982 and 2012, the American people developed an additional 44 million acres for a total of 114 million acres developed. Of all historic land development in the United States, excluding Alaska, over 37 percent has occurred since 1982. Much of this newly developed land had been existing habitats, including 17 million acres converted from forests.

A projection that the U.S. population will increase from 310 million to 439 million between 2010 and 2050 suggests that land conversion trends like these will continue. In that period, development in the residential housing sector alone may add 52 million (42% more) units, plus 37 million replacement units. By 2060, a loss of up to 38 million acres (an area the size of Florida) of forest habitats alone is possible. Attendant pressures on remaining habitats will also increase fragmentation, isolation, and

degradation through myriad indirect effects. The loss of ecological function will radiate beyond the extent of direct habitat losses. Given these projections, the near-future challenges for conserving species and habitats are daunting. As more lands and waters are developed for human uses, it is incumbent on the Service to help project proponents successfully and strategically mitigate impacts to fish and wildlife and prevent systemic losses of ecological function.

Accelerating climate change is resulting in impacts that pose a significant challenge to conserving species, habitat, and ecosystem functions. Climatic changes can have direct and indirect effects on species abundance and distribution, and may exacerbate the effects of other stressors, such as habitat fragmentation and diseases. The conservation of habitats within ecologically functioning landscapes is essential to sustaining fish, wildlife, and plant populations and improving their resilience in the face of climate change impacts, new diseases, invasive species, habitat loss, and other threats. Therefore, this policy emphasizes the integration of mitigation planning with a landscape approach to conservation.

Over the past 30 years, the concepts of adaptive management (resource management decision-making under uncertainty) have gained general acceptance as the preferred science-based approach to conservation. Adaptive management is an iterative process that involves: (a) Formulating alternative actions to meet measurable objectives; (b) predicting the outcomes of alternatives based on current knowledge; (c) conducting research that tests the assumptions underlying those predictions; (d) implementing alternatives; (e) monitoring the results; and (f) using the research and monitoring results to improve knowledge and adjust actions and objectives accordingly. Adaptive management further serves the need of most natural resources managers and policy makers to provide accountability for the outcomes of their efforts, *i.e.,* progress toward achieving defensible and transparent objectives.

Working with many partners, the Service is increasingly applying the principles of adaptive management in a landscape approach to conservation. Mitigating the impacts of actions for which the Service has advisory or regulatory authorities continues to play a significant role in accomplishing our conservation mission under this approach. Our aim with this policy is to align mitigation requirements and recommendations with conservation strategies at appropriate landscape scales so that mitigation most effectively contributes to achieving the conservation objectives we are pursuing with our partners, and to align mitigation recommendations and requirements with Secretarial Order 3330 and 600 DM.

A Focus on Habitat Conservation

Although many Service authorities pertain to specific taxa or groups of species, most specifically recognize that these resources rely on functional ecosystems to survive and persist for the continuing benefit of the American people. Mitigation is a powerful tool for sustaining species and the habitats upon which they depend; therefore, the Service's mitigation policy must effectively deal with impacts to the ecosystem functions, properties, and components that sustain fish, wildlife, plants, and their habitats. The 1981 Policy focused on habitat: ''the area which provides direct support for a given species, population, or community.'' It defined criteria for assigning the habitats of project-specific evaluation species to one of four resource categories, using a two-factor framework based on the relative scarcity of the affected habitat type and its suitability for the evaluation species, with mitigation guidelines for each category. We maintain a focus on habitats in this policy by using evaluation species and a valuation framework for their affected habitats, because habitat conservation is still generally the best means of achieving conservation objectives for species. However, our revisions of the evaluation species and habitat valuation concepts are intended to address more explicitly the landscape context of species and habitat conservation to improve mitigation effectiveness and efficiency. In addition, we recognize that some situations may require the inclusion of measures that are not habitat based to address certain species-specific impacts.

Applicability to the Endangered Species Act

The Service's 1981 mitigation policy did not apply to the conservation of species listed as threatened or endangered under the Endangered Species Act (ESA). Excluding listed species from the policy was based on: (a) A recognition that all Federal actions that could affect listed species and designated critical habitats must comply with the consultation provisions of section 7 of the ESA; and (b) a position that ''the traditional concept of mitigation'' did not apply to such actions. This policy supersedes this exclusion for the Service. Mitigation, as broadly defined in this policy, is an essential component of achieving the overarching purpose of the ESA, which is to conserve listed species and the ecosystems upon which they depend. Effective mitigation can contribute to the recovery of listed species or prevent further declines in populations and habitat resources that would otherwise slow or impede recovery of listed species.

The 1982 amendments to the ESA created incidental take permitting provisions for non-Federal actions (section 10(a)(1)(B)) with specific requirements (sections 10(a)(2)(A)(ii) and 10(a)(2)(B)(ii)) for mitigating impacts to listed species to the maximum extent practicable, and amended section 7(b) to include an incidental take statement provision for Federal agency actions that do not jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat. These amendments provide a legal means by which non-Federal and Federal actions are exempted from the prohibition against take in section 9 for endangered species and from comparable prohibitions adopted by regulation under section 4(d) for threatened species.

Mitigation, as broadly defined in this policy, does not relieve an action proponent of the obligation to secure exemption for unavoidable taking that results incidentally from otherwise lawful activities. Nevertheless, mitigation is an integral component of the section 7 and 10 processes by addressing the conservation needs of listed species within the context of the action and the impacts of the action on the species.

Under ESA section 7 the Service has consistently acknowledged and accepted or applied mitigation in the form of:

- Conservation measures voluntarily included as part of a proposed Federal action that avoid, minimize, rectify, reduce, or compensate for unavoidable (also known as residual) impacts to a listed species;
- components of a reasonable and prudent alternative to avoid jeopardizing the continued existence of listed species or destroying or adversely modifying designated critical habitat; and
- reasonable and prudent measures within an incidental take statement to minimize the impacts of taking on the affected listed species.

This policy encourages the Service to utilize a broader definition of mitigation

where allowed by law. Under section 10(a)(2), a non-Federal applicant is required to take steps ''to minimize and mitigate such impacts . . . to the maximum extent practicable,'' among other requirements to receive an incidental take permit. In addition, issuance of an incidental take permit under section 10 is a Federal action subject to the consultation requirements of section 7(a)(2).

This policy serves as over-arching Service guidance applicable to all actions for which the Service has specific authority to recommend or require the mitigation of impacts to fish, wildlife, plants, and their habitats, including those covered by the ESA. We intend to adapt Service program-specific policies, handbooks, and guidance documents, consistent with applicable statutes, to integrate the spirit and intent of this policy. For example, we anticipate publishing a Service policy specific to compensatory mitigation under the ESA that will align with the guidance described herein while providing additional operational detail.

Mitigation Policy of the U.S. Fish and Wildlife Service

1. Purpose

This policy is applicable to all actions for which the U.S. Fish and Wildlife Service (Service) has specific authority to recommend or require the mitigation of impacts to fish, wildlife, plants, and their habitats. This policy provides guidance for Service personnel. The policy allows for variations appropriate to action- and resource-specific circumstances. It will help to ensure consistent and effective recommendations by outlining policy for determining the levels of mitigation needed and the various methods for accomplishing mitigation. It will help align Service-recommended mitigation with conservation objectives for affected resources and the strategies for achieving those objectives at ecologically relevant scales. It will allow action agencies and proponents to anticipate Service recommendations and plan for mitigation measures early, thus avoiding delays and assuring equal consideration of fish and wildlife resources with other action features and purposes. This policy supersedes the Fish and Wildlife Service Mitigation Policy (46 FR 7644–7663) published in 1981. Definitions for terms used throughout this policy are provided in section 6.

2. Authority

The Service has jurisdiction over a broad range of fish and wildlife resources. Service authorities are codified under multiple statutes that address management and conservation of natural resources from many perspectives, including, but not limited to the effects of land, water, and energy development on fish, wildlife, plants, and their habitats. We list below the statutes that provide the Service, directly or indirectly through delegation from the Secretary of the Interior, specific authority for conservation of these resources and that give the Service a role in mitigation planning for actions affecting them. We further discuss the Service's mitigation planning role under each statute and list additional authorities in Appendix A.

- Bald and Golden Eagle Protection Act, 16 U.S.C. 668 *et seq.* (Eagle Act)
- Endangered Species Act of 1973, as amended, 16 U.S.C. 1531 *et seq.* (ESA)
- Federal Land and Policy Management Act, 43 U.S.C. 1701 *et seq.* (FLPMA)
- Federal Power Act, 16 U.S.C. 791–828c
- Federal Water Pollution Control Act (Clean Water Act), 33 U.S.C. 1251 *et seq.* (CWA)
- Fish and Wildlife Conservation Act, 16 U.S.C. 2901–2912
- Fish and Wildlife Coordination Act, as amended, 16 U.S.C. 661–667(e) (FWCA)
- Marine Mammal Protection Act of 1972, as amended, 16 U.S.C. 1361 *et seq.* (MMPA)
- Migratory Bird Treaty Act, 16 U.S.C. 703–712 (MBTA)
- National Environmental Policy Act, 42 U.S.C. 4371 *et seq.* (NEPA)
- National Wildlife Refuge System Administration Act, 16 U.S.C. 668dd *et seq.*

3. Scope

3.1. Actions

This policy applies to all Service activities related to evaluating the effects of proposed actions and subsequent recommendations or requirements to mitigate impacts to resources, defined in section 3.2. For purposes of this policy, actions include: (a) Activities conducted, authorized, licensed, or funded by Federal agencies (including Service-proposed activities); (b) non-Federal activities to which one or more of the Service's statutory authorities apply to make mitigation recommendations or specify mitigation requirements; and (c) the Service's provision of technical assistance to partners in collaborative mitigation planning processes that occur outside of individual action review.

3.2. Resources

This policy may apply to specific resources based on any Federal authority or combination of authorities, such as treaties, statutes, regulations, or Executive Orders, that empower the Federal Government to manage, control, or protect fish, wildlife, plants, and their habitats that are affected by proposed actions. Such Federal authority need not be exclusive, comprehensive, or primary, and in many cases, may overlap with that of States or tribes or both.

This policy applies to those resources identified in statute or implementing regulations that provide the Service authority to make mitigation recommendations or specify mitigation requirements for the actions described above. This is inclusive of, but not limited to, the federal trust fish and wildlife resources concept.

The Service has traditionally described its trust resources as migratory birds, federally listed endangered and threatened species, certain marine mammals, and inter-jurisdictional fish. Some authorities narrowly define or specifically identify covered taxa, such as threatened and endangered species, marine mammals, or the species protected by the Migratory Bird Treaty Act. This policy applies to trust resources; however, Service Regions and field stations retain discretion to engage actions on an expanded basis under appropriate authorities.

The types of resources for which the Service is authorized to recommend or require mitigation also include those that contribute broadly to ecological functions that sustain species. The definitions of the terms ''wildlife'' and ''wildlife resources'' in the Fish and Wildlife Coordination Act include birds, fishes, mammals, and all other classes of wild animals, and all types of aquatic and land vegetation upon which wildlife is dependent. Section 404 of the Clean Water Act (33 CFR 320.4) codifies the significance of wetlands and other waters of the United States as important public resources for their habitat value, among other functions. The Endangered Species Act envisions a broad consideration when describing its purposes as providing a means whereby the ecosystems upon which endangered and threatened species depend may be conserved and when directing Federal agencies at § 7(a)(1) to utilize their authorities in furtherance of the purposes of the ESA by carrying out programs for the conservation of listed species. The purpose of the National Environmental Policy Act (NEPA) also

establishes an expansive focus in promoting efforts that will prevent or eliminate damage to the environment while stimulating human health and welfare. In NEPA, Congress recognized the profound impact of human activity on the natural environment, particularly through population growth, urbanization, industrial expansion, resource exploitation, and new technologies. NEPA further recognized the critical importance of restoring and maintaining environmental quality, and declared a Federal policy of using all practicable means and measures to create and maintain conditions under which humans and nature can exist in productive harmony. These statutes address systemic concerns and provide authority for protecting habitats and landscapes.

3.3. Exclusions

This policy does not apply retroactively to completed actions or to actions specifically exempted under statute from Service review. It does not apply where the Service has already agreed to a mitigation plan for pending actions, except where: (a) New activities or changes in current activities would result in new impacts; (b) a law enforcement action occurs after the Service agrees to a mitigation plan; (c) an after-the-fact permit is issued; or (d) where new authorities, or failure to implement agreed-upon recommendations warrant new mitigation planning. Service personnel may elect to apply this policy to actions that are under review as of the date of its final publication.

3.4. Applicability to Service Actions

This policy applies to actions that the Service proposes, including those for which the Service is the lead or co-lead Federal agency for compliance with NEPA. However, it applies only to the mitigation of impacts to fish, wildlife, plants, and their habitats that are reasonably foreseeable from such proposed actions. When it is the Service that proposes an action, the Service acknowledges its responsibility to consult with Tribes, and to consider the effects to, and mitigation for, impacts to resources besides fish, wildlife, plants, and their habitats (*e.g.,* cultural and historic resources, traditional practices, environmental justice, public health, recreation, other socio-economic resources, etc.). This policy neither provides guidance nor supersedes existing guidance for mitigating impacts to resources besides those defined in section 3.2, Resources.

NEPA requires the action agency to evaluate the environmental effects of alternative proposals for agency action, including the environmental effects of proposed mitigation (*e.g.,* effects on historic properties resulting from habitat restoration). Considering impacts to resources besides fish and wildlife requires the Service to coordinate with entities having jurisdiction by law, special expertise, or other applicable authority. Appendix B further discusses the Service's consultation responsibilities with tribes related to fish and wildlife impact mitigation, *e.g.,* statutes that commonly compel the Service to address the possible environmental impacts of mitigation activities for fish and wildlife resources. It also supplements existing Service NEPA guidance by describing how this policy integrates with the Service's decision-making process under NEPA.

3.5. Financial Assistance Programs and Mitigation

The Service's 60 financial assistance programs disburse more than $1 billion annually to non-Federal recipients through grants and cooperative agreements. Most programs leverage Federal funds by requiring or encouraging the commitment of matching cash or in-kind contributions. Recipients have acquired approximately 10 million acres in fee title, conservation easements, or leases through these programs. To foster consistent application of financial assistance programs with respect to mitigation processes, Appendix C addresses the limited role that specific types of mitigation can play in financial assistance programs.

4. General Policy and Principles

The mission of the Service is working with others to conserve, protect, and enhance fish, wildlife, plants, and their habitats for the continuing benefit of the American people. In furtherance of this mission, the Service has a responsibility to ensure that impacts to fish, wildlife, plants, and their habitats in the United States, its territories, and possessions are considered when actions are planned, and that such impacts are mitigated so that these resources may provide a continuing benefit to the American people. Consistent with Congressional direction through the statutes listed in the ''Authority'' section of this policy, the Service will provide timely and effective recommendations to conserve, protect, and enhance fish, wildlife, plants, and their habitats when proposed actions may reduce the benefits thereof to the public.

Fish and wildlife and their habitats are resources that provide commercial, recreational, social, and ecological value to the Nation. For Tribal Nations, specific fish and wildlife resources and associated landscapes have traditional cultural and religious significance. Fish and wildlife are conserved and managed for the people by State, Federal, and tribal governments. If reasonably foreseeable impacts of proposed actions are likely to reduce or eliminate the public benefits that are provided by such resources, these governments have shared responsibility or interest in recommending means and measures to mitigate such losses. Accordingly, in the interest of serving the public, it is the policy of the U.S. Fish and Wildlife Service to seek to mitigate losses of fish, wildlife, plants, their habitats, and uses thereof resulting from proposed actions.

The following fundamental principles will guide Service-recommended mitigation, as defined in this policy, across all Service programs.

a. *The goal is a net conservation gain.* The Service's mitigation planning goal is to improve (*i.e.,* a net gain) or, at minimum, to maintain (*i.e.,* no net loss) the current status of affected resources, as allowed by applicable statutory authority and consistent with the responsibilities of action proponents under such authority, primarily for important, scarce, or sensitive resources, or as required or appropriate. Service mitigation recommendations or requirements will specify the means and measures that achieve this goal, as informed by established conservation objectives and strategies.

b. *Observe an appropriate mitigation sequence.* The Service recognizes it is generally preferable to take all appropriate and practicable measures to avoid and minimize adverse effects to resources, in that order, before compensating for remaining losses. However, to achieve the best possible conservation outcomes, the Service recognizes that some limited circumstances may warrant a departure from this preferred sequence. The Service will prioritize the applicable mitigation types based on a valuation of the affected resources as described in this policy in a landscape conservation context.

c. *A landscape approach will inform mitigation.* The Service will integrate mitigation into a broader ecological context with applicable landscape-level conservation plans, where available, when developing, approving, and implementing plans, and by steering mitigation efforts in a manner that will best contribute to achieving conservation objectives. The Service will consider climate change and other stressors that may affect ecosystem

integrity and the resilience of fish and wildlife populations, which will inform the scale, nature, and location of mitigation measures necessary to achieve the best possible conservation outcome. The Service will foster partnerships with Federal and State partners, tribes, and other stakeholders to design mitigation strategies that will prevent fragmented landscapes and restore core areas and connectivity necessary to sustain species.

d. *Ensure consistency and transparency.* The Service will use timely and transparent processes that provide predictability and uniformity through the consistent application of standards and protocols as may be developed to achieve effective mitigation.

e. *Science-based mitigation.* The Service will use the best available science in formulating and monitoring the long-term effectiveness of its mitigation recommendations and decisions, consistent with all applicable Service science policy.

f. *Durability.* The Service will recommend or require that mitigation measures are durable, and at a minimum, maintain their intended purpose for as long as impacts of the action persist on the landscape. The Service will recommend or require that implementation assurances, including financial, be in place when necessary to assure the development, maintenance, and long-term viability of the mitigation measure.

g. *Effective compensatory mitigation.* The Service will recommend or require that compensatory mitigation be implemented before the impacts of an action occur and be additional to any existing or foreseeably expected conservation efforts planned for the future. To ensure consistent implementation of compensatory mitigation, the Service will support application of equivalent standards regardless of the mechanism used to provide compensatory mitigation.

5. Mitigation Framework

This section of the policy provides the conceptual framework and guidance for implementing the general policy and principles declared in section 4 in an action- and landscape-specific mitigation context. Implementation of the general policy and principles as well as the direction provided in 600 DM 6 occurs by integrating landscape scale decision-making within the Service's existing process for assessing effects of an action and formulating mitigation measures. The key terms used in describing this framework are defined in section 6, Definitions.

The Service requires or recommends mitigation under one or more Federal authorities (section 2) when necessary and appropriate to avoid, minimize, and/or compensate for impacts to resources (section 3.2) resulting from proposed actions (section 3.1). Our goal for mitigation is to achieve a net conservation gain or, at minimum, no net loss of the affected resources (section 4). Sections 5.1 through 5.9, summarized below, provide an overview of the mitigation framework and describe how the Service will engage actions as part of its process of assessing the effects of an action and formulating mitigation measures that would achieve this goal. Variations appropriate to action-specific circumstances are permitted; however, the Service will provide action proponents with the reasons for such variations.

Synopsis of the Service Mitigation Framework

5.1. Integrating Mitigation Planning with Conservation Planning. The Service will utilize landscape-scale approaches and landscape conservation planning to inform mitigation, including identifying areas for mitigation that are most important for avoiding and minimizing impacts, improving habitat suitability, and compensating for unavoidable impacts to species. Advance mitigation plans can achieve efficiencies for attaining conservation objectives while streamlining the planning and regulatory processes for specific landscapes and/or classes of actions within a landscape.

5.2. Collaboration and Coordination. At both the action and landscape scales, the Service will collaborate and coordinate with action proponents and with our State, Federal, and tribal conservation partners in mitigation.

5.3. Assessment. Assessing the effects of proposed actions and proposed mitigation measures is the basis for formulating a plan to meet the mitigation policy goal. This policy does not endorse specific methodologies, but does describe several principles of effects assessment and general characteristics of methodologies that the Service will use in implementing this policy.

5.4. Evaluation Species. The Service will identify the species evaluated for mitigation purposes. The Service should select the smallest set of evaluation species necessary, but include all species for which the Service is required to issue biological opinions, permits, or regulatory determinations. When actions would affect multiple resources of conservation interest, evaluation species should serve to best represent other affected species or aspects of the environment. This section describes characteristics of evaluation species that are useful in planning mitigation.

5.5. Habitat Valuation. The Service will assess the value of affected habitats to evaluation species based on their scarcity, suitability, and importance to achieving conservation objectives. This valuation will determine the relative emphasis the Service will place on avoiding, minimizing, and compensating for impacts to habitats of evaluation species.

5.6. Means and Measures. The means and measures that the Service recommends for achieving the mitigation policy goal are action- and resource-specific applications of the three general types of impact mitigation (avoid, minimize, and compensate). This section provides an expanded definition of each type, explains its place in this policy, and lists generalized examples of its intended use in Service mitigation recommendations and requirements.

5.7. Recommendations. This section describes general standards for Service recommendations, and declares specific preferences for various characteristics of compensatory mitigation measures, *e.g.,* timing, location.

5.8. Documentation. Service involvement in planning and implementing mitigation requires documentation that is commensurate in scope and level of detail with the significance of the potential impacts to resources. This section provides an outline of documentation elements that are applicable at three different stages of the mitigation planning process: early planning, effects assessment, and final recommendations.

5.9. Follow-up. Determining whether Service mitigation recommendations were adopted and effective requires monitoring, and when necessary, corrective action.

5.1. Integrating Mitigation With Conservation Planning

The Service's mitigation goal is to improve or, at minimum, maintain the current status of affected resources, as allowed by applicable statutory authority and consistent with the responsibilities of action proponents under such authority (see section 4). This policy provides a framework for formulating mitigation means and measures (see section 5.6) intended to efficiently achieve the mitigation planning goal based upon best available science. This framework seeks to integrate mitigation requirements and recommendations into conservation

planning to better protect or enhance populations and those features on a landscape that are necessary for the long-term persistence of biodiversity and ecological functions. Functional ecosystems enhance the resilience of fish and wildlife populations challenged by the widespread stressors of climate change, invasive species, and the continuing degradation and loss of habitat through human alteration of the landscape. Achieving the mitigation goal of this policy involves:

- Avoiding and minimizing those impacts that most seriously compromise resource sustainability;
- rectifying and reducing over time those impacts where restoring or maintaining conditions in the affected area most efficiently contributes to resource sustainability; and
- strategically compensating for impacts so that actions result in an improvement in the affected resources, or at a minimum, result in a no net loss of those resources.

The Service recognizes that we will engage in mitigation planning for actions affecting resources in landscapes for which conservation objectives and strategies to achieve those objectives are not yet available, well developed, or formally adopted. The landscape-level approach to resource decisionmaking described in this policy and in the Departmental Manual (600 DM 6.6D) applies in contexts with or without established conservation plans, but it will achieve its greatest effectiveness when integrated with such planning.

Whenever required or appropriate, the Service will seek a net gain in the conservation outcome of actions we engage for purposes of this policy. It is consistent with the Service's mission to identify and promote opportunities for resource enhancement during action planning, *i.e.,* to decrease the gap between the current and desired status of a resource. Mitigation planning often presents practicable opportunities to implement mitigation measures in a manner that outweighs impacts to affected resources. When resource enhancement is also consistent with the mission, authorities, and/or responsibilities of action proponents, the Service will encourage proponents to develop measures that result in a net gain toward achieving conservation objectives for the resources affected by their actions. Such proponents include, but are not limited to, Federal agencies when responsibilities such as the following apply to their actions:

- Carry out programs for the conservation of endangered and threatened species (Endangered Species Act, section 7(a)(1));
- consult with the Service regarding both mitigation and enhancement in water resources development (Fish and Wildlife Coordination Act, section 2);
- enhance the quality of renewable resources (National Environmental Policy Act, section 101(b)(6)); and/or
- restore and enhance bird habitat (Executive Order 13186, section 3(e)(2)).

To serve the public interest in fish and wildlife resources, the Service works under various authorities (see section 2) with partners to establish conservation objectives for species, and to develop and implement plans for achieving such objectives in various landscapes. We define a landscape as an area encompassing an interacting mosaic of ecosystems and human systems that is characterized by common management concerns (see section 6, Definitions). Relative to this policy, such management concerns relate to conserving species. The geographic scale of a landscape is variable, depending on the interacting elements that are meaningful to particular conservation objectives and may range in size from large regions to a single watershed or habitat type. When proposed actions may affect species in a landscape addressed in one or more established conservation plans, such plans will provide the basis for Service recommendations to avoid and minimize particular impacts, rectify and reduce over time others, and compensate for others. The criteria in this policy for selecting evaluation species (section 5.4) and assessing the value of their affected habitats (section 5.5) are designed to place mitigation planning in a landscape conservation context by applying the various types of mitigation where they are most effective at achieving the mitigation policy goal.

The Service recognizes the inefficiency of automatically applying under all circumstances each mitigation type in the traditional mitigation sequence. As DM 6 also recognizes, in limited situations, specific circumstances may exist that warrant an alternative from this sequence, such as when seeking to achieve the maximum benefit to impacted resources and their values, services, and functions. For example, the cost and effort involved in avoiding impacts to a habitat that is likely to become isolated or otherwise unsuitable for evaluation species in the foreseeable future may result in less conservation when compared to actions that achieve a greater conservation benefit if used to implement offsite compensatory mitigation in area(s) that are more important in the long term to achieving conservation objectives for the affected resource(s). Conversely, onsite avoidance is the priority where impacts would substantially impair progress toward achieving conservation objectives.

The Service will rely upon existing conservation plans that are based upon the best available scientific information, consider climate-change adaptation, and contain specific objectives aimed at the biological needs of the affected resources. Where existing conservation plans are not available that incorporate all of these elements or are not updated with the best available scientific information, Service personnel will otherwise incorporate the best available science into mitigation decisions and recommendations and continually seek better information in areas of greatest uncertainty.

Advance Mitigation Planning at Larger Scales

The Service supports the planning and implementation of advance mitigation plans in a landscape conservation context, *i.e.,* mitigation developed before actions are proposed, particularly in areas where multiple similar actions are expected to adversely affect a similar suite of species. Advance mitigation plans should complement or tier from existing conservation plans relevant to the affected resources (*e.g.,* recovery plans, habitat conservation plans, or non-governmental plans). Effective and efficient advance mitigation identify high-priority resources and areas on a regional or landscape scale, prior to and without regard to specific proposed actions, in which to focus: (a) Resource protection for avoiding impacts; (b) resource enhancement or protection for compensating unavoidable impacts; and (c) measures to improve the resilience of resources in the face of climate change or otherwise increase the ability to adapt to climate and other landscape change factors. In many cases, the Service can take advantage of available Federal, State, tribal, local or non-governmental plans that identify such priorities.

Developing advance mitigation should involve stakeholders in a transparent process for defining objectives and the means to achieving those objectives. Planning for advance mitigation should establish standards for determining the appropriate scale, type, and location of mitigation for impacts to specific resources within a specified area. Adopted plans that incorporate these features are likely to substantially shorten the time needed for regulatory review and approval as actions are subsequently proposed. Advance mitigation plans, not limited to

those developed under a programmatic NEPA decision-making process or a Habitat Conservation Plan process, will provide efficiencies for project-level Federal actions and will also better address potential cumulative impacts.

Procedurally, advance mitigation should draw upon existing land-use plans and databases associated with human infrastructure, including transportation, and water and energy development, as well as ecological data and conservation plans for floodplains, water quality, high-value habitats, and key species. Stakeholders and Service personnel process these inputs to design a conservation network that considers needed community infrastructure and clearly prioritizes the role of mitigation in conserving natural features that are necessary for long-term maintenance of ecological functions on the landscape. As development actions are proposed, an effective advance regional mitigation plan will provide a transparent process for identifying appropriate mitigation opportunities within the regional framework and selecting the mitigation projects with the greatest aggregated conservation benefits.

5.2. Collaboration and Coordination

The Service shares responsibility for conserving fish and wildlife with State, local and tribal governments and other Federal agencies and stakeholders. Our role in mitigation may involve Service biological opinions, permits, or other regulatory determinations as well as providing technical assistance. The Service must work in collaboration and coordination with other governments, agencies, organizations, and action proponents to implement this policy. The Service will:

a. Coordinate activities with the appropriate Federal and State agencies, tribes, and other stakeholders who have responsibilities for fish and wildlife resources when developing mitigation recommendations for resources of concern to those entities;

b. to consider resources and plans made available by State, local, and tribal governments and other Federal agencies;

c. seek to apply compatible approaches and avoid duplication of efforts with those same entities;

d. collaborate with Federal and State agencies, tribes, and other stakeholders in the formulation of landscape-level mitigation plans; and

e. cooperate with partners to develop, maintain, and disseminate tools and conduct training in mitigation methodologies and technologies.

The Service should engage agencies and applicants during the early planning and design stage of actions. The Service is encouraged to engage in early coordination during the NEPA federal decision-making process to resolve issues in a timely manner (516 DM 8.3). Coordination during early planning, including participation as a cooperating agency or on interdisciplinary teams, can lead to better conservation outcomes. For example, the Federal Highway Administration (FHWA) is most likely to adopt alternatives that avoid or minimize impacts when the Service provides early comments under section 4(f) of the Transportation Act of 1966 relative to impacts to refuges or other Service-supported properties. When we identify potential impacts to tribal interests, the Service, in coordination with affected tribes, may recommend mitigation measures to address those impacts. Recommendations will carry more weight when the Service and tribe have overlapping authority for the resources in question and when coordinated through government-to-government consultation.

Coordination and collaboration with stakeholders allows the Service to confirm that the persons conducting mitigation activities, including contractors and other non-Federal persons, have the appropriate experience and training in mitigation best practices, and where appropriate, include measures in employee performance appraisal plans or other personnel or contract documents, as necessary. Similarly, this allows for the development of rigorous, clear, and consistent guidance, suitable for field staff to implement mitigation or to deny authorizations when impacts to resources and their values, services, and functions are not acceptable. Collaboratively working across Department of the Interior bureaus and offices allows the Service to conduct periodic reviews of the execution of mitigation activities to confirm consistent implementation of the principles of this policy.

5.3. Assessment

Effects are changes in environmental conditions caused by an action that are relevant to the resources (fish, wildlife, plants, and their habitats) covered by this policy. This policy addresses mitigation for impacts to these resources. We define impacts as adverse effects relative to the affected resources. Mitigation is the general label for all measures implemented as part of an action to avoid, minimize, and/or compensate for its predicted impacts.

The Service should design mitigation measures to achieve the mitigation goal of net gain, as required or appropriate, or a minimum of no net loss for affected resources. This design should take into account the degree of risk and uncertainty associated with both predicted project effects and predicted outcomes of the mitigation measures. The following principles shall guide the Service's assessment of anticipated effects and the expected effectiveness of mitigation measures.

1. The Service will consider action effects and mitigation outcomes within planning horizons commensurate with the expected duration of the action's impacts. In predicting whether mitigation measures will achieve the mitigation policy goal for the affected resources during the planning horizon, the Service will recognize that predictions about the more-distant future are more uncertain and adjust the mitigation recommendations accordingly.

2. Action proponents should provide reasonable predictions about environmental conditions relevant to the affected area both with and without the action over the course of the planning horizon (*i.e.,* baseline condition). If such predictions are not provided, the Service will assess the effects of a proposed action over the planning horizon considering: (a) the full spatial and temporal extent of resource-relevant direct and indirect effects caused by the action, including resource losses that will occur during the period between implementation of the action and the mitigation measures; and (b) any cumulative effects to the affected resources resulting from existing concurrent or reasonably foreseeable future activities in the landscape context. When assessing the affected area without the action, the Service will also evaluate: (a) expected natural species succession; (b) implementation of approved restoration/improvement plans; and (c) reasonably foreseeable conditions resulting directly or indirectly from any other factors that may affect the evaluation of the project, including, but not limited to, climate change.

3. The Service will use the best available effect assessment methodologies that:

a. Display assessment results in a manner that allows decision-makers, action proponents, and the public to compare present and predicted future conditions for affected resources;

b. measure adverse and beneficial effects using common metrics to determine mitigation measures necessary to achieve the mitigation policy goal for the affected resources;

c. predict effects over time, including changes to affected resources that would occur with and without the action, changes induced by climate change, and changes resulting from reasonably foreseeable actions;

d. are practical, cost-effective, and commensurate with the scope and scale of impacts to affected resources;

e. are sufficiently sensitive to estimate the type and relative magnitude of effects across the full spectrum of anticipated beneficial and adverse effects;

f. may integrate predicted effects with data from other disciplines such as cost or socioeconomic analysis; and

g. allow for incorporation of new data or knowledge as action planning progresses.

4. Where appropriate effects assessment methods or technologies useful in valuation of mitigation are not available, Service employees will apply best professional judgment supported by best available science to assess impacts and to develop mitigation recommendations.

5.4. Evaluation Species

Section 3.2 identifies the resources to which this policy applies. Depending on the authorities under which the Service is engaging an action for mitigation purposes, these resources may include: Particular species; fish, wildlife, and plants more generally; and their habitats, including those contributing to ecological functions that sustain species. Always, however, one or more species of conservation interest to the Service is necessary to initiate mitigation planning, and under this policy, the Service will explicitly identify evaluation species for mitigation purposes. In instances where the Service is required to issue a biological opinion, permit, or regulatory determination for specific species, the Service will identify such species, at minimum, as evaluation species.

Selecting evaluation species in addition to those for which the Service must provide a regulatory determination varies according to action-specific circumstances. In practice, an initial examination of the habitats affected and review of typically associated species of conservation interest are usually the first steps in identifying evaluation species. The purpose of Service mitigation planning is to develop a set of recommendations that would improve or, at minimum, maintain the current status of the affected resources. When available, conservation planning objectives (*i.e.,* the desired status of the affected resources) will inform mitigation planning (see section 5.1). Therefore, following those species for which we must provide a regulatory determination, species for which action effects would cause the greatest increase in the gap between their current and desired status are the principal choices for selection as evaluation species.

An evaluation species must occur within the affected area for at least one stage of its life history, but as other authorities permit, the Service may consider evaluation species that are not currently present in the affected area if the species is:

a. Identified in approved State or Federal fish and wildlife conservation, restoration, or improvement plans that include the affected area; or

b. likely to occur in the affected area during the reasonably foreseeable future with or without the proposed action due to natural species succession.

Evaluation species may or may not occupy the affected area year-round or when direct effects of the action would occur.

The Service should select the smallest set of evaluation species necessary to relate the effects of an action to the full suite of affected resources and applicable authorities, including all species for which the Service is required to issue opinions, permits, or regulatory determinations. When an action affects multiple resources, evaluation species should represent other affected species or aspects of the environment so that the mitigation measures formulated for the evaluation species will mitigate impacts to other similarly affected resources to the greatest extent possible. Characteristics of evaluation species that are useful in mitigation planning may include, but are not limited to, the following:

a. Species that are addressed in conservation plans relevant to the affected area and for which habitat objectives are articulated;

b. species strongly associated with an affected habitat type;

c. species for which habitat limiting factors are well understood;

d. species that perform a key role in ecological processes (*e.g.,* nutrient cycling, pollination, seed dispersal, predator-prey relations), which may, therefore, serve as indicators of ecosystem health;

e. species that require large areas of contiguous habitat, connectivity between disjunct habitats, or a distribution of suitable habitats along migration/movement corridors, which may, therefore, serve as indicators of ecosystem functions;

f. species that belong to a group of species (a guild) that uses a common environmental resource;

g. species for which sensitivity to one or more anticipated effects of the proposed action is documented;

h. species with special status (*e.g.,* species of concern in E.O. 13186, Birds of Conservation Concern);

i. species of cultural or religious significance to tribes;

j. species that provide monetary and non-monetary benefits to people from consumptive and non-consumptive uses including, but not limited to, fishing, hunting, bird watching, and educational, aesthetic, scientific, or subsistence uses;

k. species with characteristics such as those above that are also easily monitored to evaluate the effectiveness of mitigation actions and/or

l. species that would be subject to direct mortality as a result of an action (*e.g.* wind turbine).

5.5. Habitat Valuation

Species conservation relies on functional ecosystems, and habitat conservation is generally the best means of achieving species population objectives. Section 5.4 provides the guidance for selecting evaluation species to represent these habitat resources. The value of specific habitats to evaluation species varies widely, such that the loss or degradation of higher-value habitats has a greater impact on achieving conservation objectives than the loss or degradation of an equivalent area of lower-value habitats. To maintain landscape capacity to support species, our mitigation policy goal (Section 4) applies to all affected habitats of evaluation species, regardless of their value in a conservation context. However, the Service will recognize variable habitat value in formulating appropriate means and measures to mitigate the impacts of proposed actions, as described in this section. The primary purpose of habitat valuation is to determine the relative emphasis the Service will place on avoiding, minimizing, and compensating for impacts to habitats of evaluation species.

The Service will assess the overall value of affected habitats by considering their: (a) Scarcity; (b) suitability for evaluation species; and (c) importance to the conservation of evaluation species.

- *Scarcity* is the relative spatial extent (*e.g.,* rare, common, or abundant) of the habitat type in the landscape context.
- *Suitability* is the relative ability of the affected habitat to support one or more elements of the evaluation species' life history (reproduction, rearing, feeding, dispersal, migration,

hibernation, or resting protected from disturbance, etc.) compared to other similar habitats in the landscape context. A habitat's ability to support an evaluation species may vary over time.

• *Importance* is the relative significance of the affected habitat, compared to other similar habitats in the landscape context, to achieving conservation objectives for the evaluation species. Habitats of high importance are irreplaceable or difficult to replace, or are critical to evaluation species by virtue of their role in achieving conservation objectives within the landscape (*e.g.,* sustain core habitat areas, linkages, ecological functions). Areas containing habitats of high importance are generally, but not always, identified in conservation plans addressing resources under Service authorities (*e.g.,* in recovery plans) or when appropriate, under authorities of partnering entities (*e.g.,* in State wildlife action plans, Landscape Conservation Cooperative conservation ''blueprints,'' etc.).

The Service has flexibility in applying appropriate methodologies and best available science when assessing the overall value of affected habitats, but also has a responsibility to communicate the rationale applied, as described in section 5.8 (Documentation Standards). These three parameters are the considerations that will inform Service determinations of the relative value of an affected habitat that will then be used to guide application of the mitigation hierarchy under this policy.

For all habitats, the Service will apply appropriate and practicable measures to avoid and minimize impacts over time, generally in that order, before applying compensation as mitigation for remaining impacts. For habitats we determine to be of high value, however, the Service will seek avoidance of all impacts. For habitats the Service determines to be of lower value, we will consider whether compensation is more effective than other components of the mitigation hierarchy to maintain the current status of evaluation species, and if so, may seek compensation for most or all such impacts.

The relative emphasis given to mitigation types within the mitigation hierarchy depends on the landscape context and action-specific circumstances that influence the efficacy and efficiency of available mitigation means and measures. For example, it is generally more effective and efficient to achieve the mitigation policy goal by maximizing avoidance and minimization of impacts to habitats that are either rare, of high suitability, or of high importance, than to rely on other measures, because these qualities are typically not easily repaired, enhanced through on-site management, or replaced through compensatory actions. Similarly, compensatory measures may receive greater emphasis when strategic application of such measures (*i.e.,* to further the objectives of relevant conservation plans) would more effectively and efficiently achieve the policy goal for mitigating impacts to habitats that are either abundant, of low suitability, or of low importance.

When more than one evaluation species uses an affected habitat, the highest valuation will govern the Service's mitigation recommendations or requirements. Regardless of the habitat valuation, Service mitigation recommendations will represent our best judgment as to the most practicable means of ensuring that a proposed action improves or, at minimum, maintains the current status of the affected resources.

5.6. Means and Measures

The means and measures that the Service recommends for achieving the goal of this policy (see section 4) are action- and resource-specific applications of the five general types of impact mitigation: Avoid, minimize, rectify, reduce over time, and compensate. The third and fourth mitigation types, rectify and reduce over time, are combined under the minimization label (*e.g.,* in mitigation planning for permitting actions under the Clean Water Act, in the Presidential Memorandum on Mitigating Impacts on Natural Resources from Development and Encouraging Related Private Investment, and in 600 DM 6.4), which we adopt for this policy and for the structure of this section, while also providing specific examples for rectify and reduce. When carrying out its responsibilities under NEPA, the Service will apply the mitigation meanings and sequence in the NEPA regulations (40 CFR 1508.20). In particular, the Service will retain the ability to distinguish, as needed, between minimizing, rectifying, and reducing or eliminating the impact over time, as described in Appendix B: Service Mitigation Policy and NEPA.

The emphasis that the Service gives to each mitigation type depends on the evaluation species selected (section 5.4) and the value of their affected habitats (section 5.5). Habitat valuation aligns mitigation with conservation planning for the evaluation species by identifying where it is critical to avoid habitat impacts altogether and where compensation measures may more effectively advance conservation objectives. All appropriate mitigation measures have a clear connection with the anticipated effects of the action and are commensurate with the scale and nature of those effects.

Nothing in this policy supersedes the statutes and regulations governing prohibited ''take'' of wildlife (*e.g.,* ESA-listed species, migratory birds, eagles); however, the policy applies to mitigating the impacts to habitats and ecological functions that support populations of evaluation species, including federally protected species. Attaining the goal of improving or, at a minimum, maintaining the current status of evaluation species will often involve applying a combination of mitigation types. For each of the mitigation types, the following subsections begin with a quote of the regulatory language at 40 CFR 1508.20, then provides an expanded definition, explains its place in this policy, and lists generalized examples of its intended use in Service mitigation recommendations. Ensuring that Service-recommended mitigation measures are implemented and effective is addressed in sections 5.8, Documentation, and 5.9, Follow-up.

5.6.1. Avoid

''Avoid the impact altogether by not taking a certain action or parts of an action.'' Avoiding impacts is the first tier of the mitigation hierarchy. Avoidance ensures that an action or a portion of the action has no direct or indirect effects during the planning horizon on fish, wildlife, plants, and their habitats. Actions may avoid direct effects to a resource (*e.g.,* by shifting the location of the construction footprint), but unless the action also avoids indirect effects caused by the action (*e.g.,* loss of habitat suitability through isolation from other habitats, accelerated invasive species colonization, degraded water quality, etc.), the Service will not consider that impacts to a resource are fully avoided. In some cases, indirect effects may cumulatively result in population and habitat losses that negate any conservation benefit from avoiding direct effects. An impact is unavoidable when an appropriate and practicable alternative to the proposed action that would not cause the impact is unavailable. The Service will recommend avoiding all impacts to high-value habitats. Generalized examples follow:

a. Design the timing, location, and/or operations of the action so that specific resource impacts would not occur.

b. Add structural features to the action, where such action is sustainable

(*e.g.,* fish and wildlife passage structures, water treatment facilities, erosion control measures) that would eliminate specific losses to affected resources.

c. Adopt a non-structural alternative to the action that is sustainable and that would not cause resource losses (*e.g.,* stream channel restoration with appropriate grading and vegetation in lieu of rip-rap).

d. Adopt the no-action alternative.

5.6.2. Minimize (Includes Rectify and Reduce Over Time)

''Minimize the impact by limiting the degree or magnitude of the action and its implementation.'' Minimizing impacts, together with rectifying and reducing over time, is the second tier of the mitigation hierarchy. Minimizing is reducing the intensity of the impact (*e.g.,* population loss, habitat loss, reduced habitat suitability, reduced habitat connectivity, etc.) to the maximum extent appropriate and practicable. Generalized examples of types of measures to minimize impacts follow:

a. Reduce the overall spatial extent and/or duration of the action.

b. Adjust the daily or seasonal timing of the action.

c. Retain key habitat features within the affected area that would continue to support life-history processes for the evaluation species.

d. Adjust the spatial configuration of the action to retain corridors for species movement between functional habitats.

e. Apply best management practices to reduce water quality degradation.

f. Adjust the magnitude, timing, frequency, duration, and/or rate-of-change of water flow diversions and flow releases to minimize the alteration of flow regime features that support life-history processes of evaluation species.

g. Install screens and other measures necessary to reduce aquatic life entrainment/impingement at water intake structures.

h. Install fences, signs, markers, and other measures necessary to protect resources from impacts (*e.g.,* fencing riparian areas to exclude livestock, marking a heavy-equipment exclusion zone around burrows, nest trees, and other sensitive areas).

Rectify. This subset of the second tier of the mitigation hierarchy involves ''repairing, rehabilitating, or restoring the affected environment.'' Rectifying impacts may possibly improve relative to no-action conditions a loss in habitat availability and/or suitability for evaluation species within the affected area and contribute to a net conservation gain. Rectifying impacts may also involve directly restoring a loss in populations through stocking. Generalized examples follow:

a. Repair physical alterations of the affected areas to restore pre-action conditions or improve habitat suitability for the evaluation species (*e.g.,* re-grade staging areas to appropriate contours, loosen compacted soils, restore altered stream channels to stable dimensions).

b. Plant and ensure the survival of appropriate vegetation where necessary in the affected areas to restore or improve habitat conditions (quantity and suitability) for the evaluation species and to stabilize soils and stream channels.

c. Provide for fish and wildlife passage through or around action-imposed barriers to movement.

d. Consistent with all applicable laws, regulations, policies, and conservation plans, stock species that experienced losses in affected areas when habitat conditions are able to support them in affected areas.

Reduce Over Time. This subset of the second tier of the mitigation hierarchy is to ''reduce or eliminate the impact over time by preservation and maintenance operations during the life of the action.'' Reducing impacts over time is preserving, enhancing, and maintaining the populations, habitats, and ecological functions that remain in an affected area following the impacts of the action, including areas that are successfully restored or improved through rectifying mitigation measures. Preservation, enhancement, and maintenance operations may improve upon conditions that would occur without the action and contribute to a net conservation gain (*e.g.,* when such operations would prevent habitat degradation expected through lack of management needed for an evaluation species). Reducing impacts over time is an appropriate means to achieving the mitigation goal after applying all appropriate and practicable avoidance, minimization, and rectification measures. Generalized examples follow:

a. Control land uses and limit disturbances to portions of the affected area that may continue to support the evaluation species.

b. Control invasive species in the affected areas.

c. Manage fire-adapted habitats in the affected areas with an appropriate timing and frequency of prescribed fire, consistent with applicable laws, regulations, policies, and conservation plans.

d. In affected areas, maintain or replace equipment and structures to prevent losses of fish and wildlife resources due to equipment failure (*e.g.,* cleaning and replacing trash racks and water intake screens, maintaining fences that limit access to environmentally sensitive areas).

e. Ensure proper training of personnel in operations necessary to preserve existing or restored fish and wildlife resources in the affected area.

5.6.3. Compensate

''Compensate for the impact by replacing or providing substitute resources or environments.'' Compensating for impacts is the third and final tier of the mitigation hierarchy. Compensation is protecting, maintaining, enhancing, and/or restoring habitats and ecological functions for an evaluation species, generally in an area outside the action's affected area. Mitigating some percentage of unavoidable impacts through measures that minimize, rectify, and reduce losses over time is often appropriate and practicable, but the costs or difficulties of mitigation may rise rapidly thereafter to achieve the mitigation planning goal entirely within the action's affected area. In such cases, a lesser or equivalent effort applied in another area may achieve greater benefits for the evaluation species. Likewise, the effort necessary to mitigate the impacts to a habitat of low suitability and low importance of a type that is relatively abundant in the landscape context (low-value habitat) will more likely achieve sustainable benefits for an evaluation species if invested in enhancing a habitat of moderate suitability and high importance. This policy is designed to apply the various types of mitigation where they may achieve the greatest efficiency toward accomplishing the mitigation planning goal.

The Service encourages proponents to offset unavoidable resource losses in advance of their actions. Further, the Service considers the banking of habitat value for the express purpose of compensating for future unavoidable losses to be a legitimate form of mitigation, provided that withdrawals from a mitigation/conservation bank are commensurate with losses of habitat value (considering suitability and importance) for the evaluation species and not based solely upon the affected habitat acreage or the cost of land purchase and management. Resource losses compensated through purchase of conservation or mitigation bank credits may include, but are not limited to, habitat impacts to species covered by one or more Service authorities.

The mechanisms for delivering compensatory mitigation differ according to: (1) Who is ultimately

responsible for the success of the mitigation (the action proponent or a third party); (2) whether the mitigation site is within or adjacent to the impact site (on-site) or at another location that provides either equivalent or additional resource value (offsite); and (3) when resource benefits are secured (before or after resource impacts occur). Regardless of the delivery mechanism, species conservation strategies and other landscape-level conservation plans that are based on the best scientific information available are expected to provide the basis for establishing and operating compensatory mitigation sites and programs. Such strategies and plans should also inform the assessment of species-specific impacts and benefits within a defined geography. The Service will ensure the application of equivalent ecological, procedural, and administrative standards for all compensatory mitigation mechanisms. As outlined by DM 6.6 C, this means that compensatory mitigation measures will maximize the benefit to impacted resources; implement and earn credits in advance of impacts; reduce risk to achieving effectiveness; use transparent methodologies; and use mitigation measures with equivalent standards that clearly identify responsible parties and that establish monitoring. Mitigation options delivered through any compensatory mitigation mechanism must incorporate, address, or identify the following that are intended to ensure successful implementation and durability:

a. Type of resource(s) and/or its values(s), service(s) and function(s), and amount(s) of such resources to be provided (usually expressed in acres or some other physical measure), the method of compensation (restoration, establishment, preservation, etc.), and the manner in which a landscape-scale approach has been considered;

b. factors considered during the site selection process;

c. site protection instruments to ensure the durability of the measure;

d. baseline information;

e. the mitigation value of such resources (usually expressed as a number of credits or other units of value), including a rationale for such a determination;

f. a mitigation work plan including the geographic boundaries of the measure, construction methods, timing, and other considerations;

g. a maintenance plan;

h. performance standards to determine whether the measure has achieved its intended outcome;

i. monitoring requirements;

j. long-term management commitments;

k. adaptive management commitments; and

l. financial assurance provisions that are sufficient to ensure, with a high degree of confidence, that the measure will achieve and maintain its intended outcome, in accordance with the measure's performance standards.

Multiple mechanisms may be used to provide compensatory mitigation, including habitat credit exchanges and other emerging mechanisms. Proponent-responsible mitigation, mitigation/conservation banks, and in-lieu fee funds are the three most common mechanisms. Descriptions of their general characteristics follow:

a. *Proponent-Responsible Mitigation.* A proponent-responsible mitigation site provides ecological functions and services in accordance with Service-defined or -approved standards to offset the habitat impacts of a proposed action on particular species. As its name implies, the action proponent is solely responsible for ensuring that the compensatory mitigation activities are completed and successful. Proponent-responsible mitigation may occur on-site or off-site relative to action impacts. Like all compensatory mitigation measures, proponent-responsible mitigation should: (a) Maximize the benefit to impacted resources and their values, services, and functions; (b) implement and earn credits in advance of project impacts; and (c) reduce risk to achieving effectiveness.

b. *Mitigation/Conservation Banks.* A conservation bank is a site or suite of sites that provides ecological functions and services expressed as credits that are conserved and managed in perpetuity for particular species and are used expressly to offset impacts occurring elsewhere to the same species. A mitigation bank is established to offset impacts to wetland habitats under section 404 of the Clean Water Act. Some mitigation banks may also serve the species-specific purposes of a conservation bank. Mitigation and conservation banks are typically for-profit enterprises that apply habitat restoration, creation, enhancement, and/or preservation techniques to generate credits on their banking properties. The establishment, operation, and use of a conservation bank requires a conservation bank agreement between the Service and the bank sponsor, and aquatic resource mitigation banks require a banking instrument approved by the U.S. Army Corps of Engineers. Responsibility for ensuring that compensatory mitigation activities are successfully completed is transferred from the action proponent to the bank sponsor at the time of the sale/transfer of credits. Mitigation and conservation banks generally provide mitigation in advance of impacts.

c. *In-Lieu Fee.* An in-lieu fee site provides ecological functions and services expressed as credits that are conserved and managed for particular species or habitats, and are used expressly to offset impacts occurring elsewhere to the same species or habitats. In-lieu fee programs are sponsored by governmental or non-profit entities that collect funds used to establish in-lieu fee sites. In-lieu fee program operators apply habitat restoration, creation, enhancement, and/or preservation techniques to generate credits on in-lieu fee sites. The establishment, operation, and use of an in-lieu fee program may require an agreement between regulatory agencies of applicable authority, including the Service, and the in-lieu fee program operator. Responsibility for ensuring that compensatory mitigation activities are successfully completed is transferred from the action proponent to the in-lieu fee program operator at the time of sale/transfer of credits. Unlike mitigation or conservation banks, in-lieu fee programs generally provide compensatory mitigation after impacts have occurred. See section 5.7.2 for discussion of the Service's preference for compensatory mitigation that occurs prior to impacts.

Research and education, although important to the conservation of many resources, are not typically considered compensatory mitigation. This is because they do not, by themselves, replace impacted resources or adequately compensate for adverse effects to species or habitat. In rare circumstances, research or education that can be linked directly to threats to the resource and provide a quantifiable benefit to the resource may be included as part of a mitigation package. These circumstances may include: (a) When the major threat to a resource is something other than habitat loss; (b) when the Service can reasonably expect the benefits of applying the research or education results to more than offset the impacts; (c) where there is an adaptive management approach wherein the results/recommendations of the research will then be applied to improve mitigation of the impacts of the project or proposal; or (d) there are no other reasonable options for mitigation.

5.7. Recommendations

Consistent with applicable authorities, the policy's fundamental principles, and the mitigation planning

principles described herein, the Service will provide recommendations to mitigate the impacts of proposed actions at the earliest practicable stage of planning to ensure maximum consideration. The Service will develop mitigation recommendations in cooperation with the action proponent and/or the applicable authorizing agency, considering the cost estimates and other information that the proponent/agency provides about the action and its effects, and relying on the best scientific information available. Service recommendations will represent our best judgment as to the most practicable means of ensuring that a proposed action improves or, at minimum maintains, the current status of the affected resources. The Service will provide mitigation recommendations under an explicit expectation that the action proponent or the applicable authorizing agency is fully responsible for implementing or enforcing the recommendations.

The Service will strive to provide mitigation recommendations, including reasonable alternatives to the proposed action, which, if fully and properly implemented, would achieve the best possible outcome for affected resources while also achieving the stated purpose of the proposed action. However, on a case-by-case basis, the Service may recommend the ''no action'' alternative. For example, when appropriate and practicable means of avoiding significant impacts to high-value habitats and associated species are not available, the Service may recommend the ''no action'' alternative.

5.7.1. Preferences

Unless action-specific circumstances warrant otherwise, the Service will observe the following preferences in providing mitigation recommendations or requirements:

Advance compensatory mitigation. When compensatory mitigation is necessary, the Service prefers compensatory mitigation measures that are implemented and earn credits in advance of project impacts. The extent of the compensatory measures that are not completed until after action impacts occur will account for the interim loss of resources consistent with the assessment principles (section 5.3).

Compensatory mitigation in relation to landscape strategies and plans. The preferred location for Service-recommended or required compensatory mitigation measures is within the boundaries of an existing strategically planned, interconnected conservation network that serves the conservation objectives for the affected resources in the relevant landscape context. Compensatory measures should enhance habitat connectivity or contiguity, or strategically improve targeted ecological functions important to the affected resources (*e.g.,* enhance the resilience of fish and wildlife populations challenged by the wide-spread stressors of climate change).

Similarly, Service-recommended or required mitigation should emphasize avoiding impacts to habitats located within a planned conservation network, consistent with the Habitat Valuation guidance (section 5.5).

Where existing conservation networks or landscape conservation plans are not available for the affected resources, Service personnel should develop mitigation recommendations and requirements based on best available scientific information and professional judgment that would maximize the effectiveness of the mitigation measures for the affected resources, consistent with this policy's guidance on Integrating Mitigation Planning with Conservation Planning (section 5.1).

5.7.2. Recommendations for Locating Mitigation on Public or Private Lands

When appropriate as specified in this policy, the Service may recommend establishing compensatory mitigation at locations on private, public, or tribal lands that provide the maximum conservation benefit for the affected resources. The Service will generally, but not always, recommend compensatory mitigation on lands with the same ownership classification as the lands where impacts occurred, *e.g.,* impacts to evaluation species on private lands are generally mitigated on private lands and impacts to evaluation species on public lands are generally mitigated on public lands. However, most private lands are not permanently dedicated to conservation purposes, and are generally the most vulnerable to impacts resulting from land and water resources development actions; therefore, mitigating impacts to any type of land ownership on private lands is usually acceptable as long as they are durable. Locating compensatory mitigation on public lands for impacts to evaluation species on private lands is also possible, and in some circumstances may best serve the conservation objectives for evaluation species. Such compensatory mitigation options require careful consideration and justification relative to the Service's mitigation planning goal, as described below.

The Service generally only supports locating compensatory mitigation on (public or private) lands that are already designated for the conservation of natural resources if additionality (see section 6, Definitions) is clearly demonstrated and is legally attainable. In particular, the Service usually does not support offsetting impacts to private lands by locating compensatory mitigation on public lands designated for conservation purposes because this practice risks a long-term net loss in landscape capacity to sustain species by relying increasingly on public lands to serve conservation purposes. However, the Service acknowledges that public ownership does not automatically confer long-term protection and/or management for evaluation species in all cases, which may justify locating compensatory mitigation measures on public lands, including compensation for impacts to evaluation species on public or private lands. The Service may recommend compensating for private-land impacts to evaluation species on public lands (whether designated for conservation of natural resources or not) when:

a. Compensation is an appropriate means of achieving the mitigation planning goal, as specified in this policy;

b. the compensatory mitigation would provide additional conservation benefits above and beyond measures the public agency is foreseeably expected to implement absent the mitigation (Only such additional benefits are counted towards achieving the mitigation planning goal.);

c. the additional conservation benefits are durable, *i.e.,* lasting as long as the impacts that prompted the compensatory mitigation;

d. consistent with and not otherwise prohibited by all relevant statutes, regulations, and policies; and

e. the public land location would provide the best possible conservation outcome, such as when private lands suitable for compensatory mitigation are unavailable or are available but do not provide an equivalent or greater contribution towards offsetting the impacts to meet the mitigation planning goal for the evaluation species.

Ensuring the durability of compensatory mitigation on public lands may require multiple tools beyond land use plan designations, including right-of-way grants, withdrawals, disposal or lease of land for conservation, conservation easements, cooperative agreements, and agreements with third parties. Mechanisms to ensure durability of land protection for compensatory mitigation on public and private lands vary among agencies, but should preclude conflicting uses and ensure that protection and management of the mitigation land is commensurate

with the magnitude and duration of impacts.

When the public lands under consideration for use as compensatory mitigation for impacts on private lands are National Wildlife Refuge System (NWRS) lands, additional considerations covered in the Service's Final Policy on the NWRS and Compensatory Mitigation Under the Section 10/404 Program (64 FR 49229–49234, September 10, 1999) may apply. Under that policy, the Regional Director will recommend the mitigation plan proposing to site compensatory mitigation on NWRS lands to the Director for approval.

5.7.3. Recommendations Related to Recreation

Mitigation for impacts to recreational uses of wildlife and habitat. The Service will generally not recommend measures intended to increase recreational value as mitigation for habitat losses. The Service may address impacts to recreational uses that are not otherwise addressed through habitat mitigation, but will do so with separate and distinct recreational use mitigation recommendations.

Recreational use of mitigation lands. Consistent with applicable statutes, the Service supports those recreational uses on mitigation lands that are compatible with the conservation goals of those mitigation lands. If certain uses are incompatible with the conservation goals for the mitigation lands, the Service will recommend against such uses.

5.8. Documentation

The Service should advise action proponents and decision-making agencies at timely stages of the planning process. To ensure effective consideration of Service recommendations, it is generally possible to communicate key concerns that will inform our recommendations early in the mitigation planning process, communicate additional components during and following an initial assessment of effects, and provide final written recommendations toward the end of the process, but in advance of a final decision for the action. The following outline lists the components applicable to these three planning stages. Because actions vary substantially in scope and complexity, these stages may extend over a period of years or occur almost simultaneously, which may necessitate consolidating some of the components listed below. For all actions, the level of the Service's analysis and documentation should be commensurate with the scope and severity of the potential impacts to resources.

A. Early Planning

1. Inform the proponent of the Service's goal to improve or, at minimum, maintain the status of affected resources, and that the Service will identify opportunities for a net conservation gain if required or appropriate.

2. Coordinate key data collection and planning decisions with the proponent, relevant tribes, and Federal and State resource agencies; including, but not limited to:

a. Delineate the affected area;

b. define the planning horizon;

c. identify species that may occur in the affected area that the Service is likely to consider as evaluation species for mitigation planning;

d. identify landscape-scale strategies and conservation plans and objectives that pertain to these species and the affected area;

e. define surveys, studies, and preferred methods necessary to inform effects analyses; and

f. as necessary, identify reasonable alternatives to the proposed action that may achieve the proponent's purpose and the Service's no-net-loss goal for resources.

3. As early as possible, inform the proponent of the presence of probable high-value habitats in the affected area (see Section 5.5), and advise the proponent of Service policy to avoid all impacts to such habitats.

B. Effects Assessment

1. Coordinate selection of evaluation species with relevant tribes, Federal and State resource agencies, and action proponents.

2. Communicate the Service's assessment of the value of affected habitats to evaluation species.

3. If high-value habitats are affected, advise the proponent of the Service's policy to avoid all impacts to such habitats.

4. Assess action effects to evaluation species and their habitats.

5. Formulate mitigation options that would achieve the mitigation policy goal (an appropriate net conservation gain or, at minimum, no net loss) in coordination with the proponent and relevant tribes, and Federal and State resource agencies.

C. Final Recommendations

The Service's final mitigation recommendations should communicate in writing the following:

1. The authorities under which the Service is providing the mitigation recommendations consistent with this policy.

2. A description of all mitigation measures that the Service believes are reasonable and appropriate to ensure that the proposed action improves or, at minimum, maintains the current status of affected fish, wildlife, plants, and their habitats.

3. The following elements should be specified within a mitigation plan or equivalent by either the Service, action proponents, or in collaboration:

a. Measurable objectives;

b. implementation assurances, including financial, as applicable;

c. effectiveness monitoring;

d. additional adaptive management actions as may be indicated by monitoring results; and

e. reporting requirements.

4. An explanation of the basis for the Service recommendations, including, but not limited to:

a. Evaluation species used for mitigation planning;

b. the assessed value (high, moderate, low) of affected habitats to evaluation species;

c. predicted adverse and beneficial effects of the proposed action;

d. predicted adverse and beneficial effects of the recommended mitigation measures; and

e. the rationale for our determination that the proposed action, if implemented with Service recommendations, would achieve the mitigation policy goal.

5. The Service's expectations of the proponent's responsibility to implement the recommendations.

5.9. Follow-up

The Service encourages, supports, and will initiate, whenever practicable, post-action monitoring studies and evaluations to determine the effectiveness of recommendations in achieving the mitigation planning goal. In those instances where Service personnel determine that action proponents have not carried out those agreed-upon mitigation means and measures, the Service will request that the parties responsible for regulating the action initiate corrective measures, or will initiate access to available assurance measures. These provisions also apply when the Service is the action proponent.

6. Definitions

Definitions in this section apply to the implementation of this policy and were developed to provide clarity and consistency within the policy itself, and to ensure broad, general applicability to all mitigation processes in which the

Service engages. Some Service authorities define some of the terms in this section differently or more specifically, and the definitions herein do not substitute for statutory or regulatory definitions in the exercise of those authorities.

Action. An activity or program implemented, authorized, or funded by Federal agencies; or a non-Federal activity or program for which one or more of the Service's authorities apply to make mitigation recommendations, specify mitigation requirements, or provide technical assistance for mitigation planning.

Additionality. A compensatory mitigation measure is additional when the benefits of a compensatory mitigation measure improve upon the baseline conditions of the impacted resources and their values, services, and functions in a manner that is demonstrably new and would not have occurred without the compensatory mitigation measure.

Affected area. The spatial extent of all effects, direct and indirect, of a proposed action to fish, wildlife, plants, and their habitats.

Affected resources. Those resources, as defined by this policy, that are subject to the adverse effects of an action.

Compensatory mitigation. Compensatory mitigation means to compensate for remaining unavoidable impacts after all appropriate and practicable avoidance and minimization measures have been applied, by replacing or providing substitute resources or environments (See 40 CFR 1508.20.) through the restoration, establishment, enhancement, or preservation of resources and their values, services, and functions. Impacts are authorized pursuant to a regulatory or resource management program that issues permits, licenses, or otherwise approves activities. In this policy, ''mitigation'' is a deliberate expression of the full mitigation hierarchy, and ''compensatory mitigation'' describes only the last phase of that sequence.

Conservation. In the context of this policy, the noun ''conservation'' is a general label for the collective practices, plans, policies, and science that are used to protect and manage species and their habitats to achieve desired outcomes.

Conservation objective. A measurable expression of a desired outcome for a species or its habitat resources. Population objectives are expressed in terms of abundance, trend, vital rates, or other measurable indices of population status. Habitat objectives are expressed in terms of the quantity, quality, and spatial distribution of habitats required to attain population objectives, as informed by knowledge and assumptions about factors influencing the ability of the landscape to sustain species.

Conservation planning. The identification of strategies for achieving conservation objectives. Conservation plans include, but are not limited to, recovery plans, habitat conservation plans, watershed plans, green infrastructure plans, and others developed by Federal, tribal, State, or local government agencies or non-governmental organizations. This policy emphasizes the use of landscape-scale approaches to conservation planning.

Durability. A mitigation measure is durable when the effectiveness of the measure is sustained for the duration of the associated impacts of the action, including direct and indirect impacts.

Effects. Changes in environmental conditions that are relevant to the resources covered by this policy.

Direct effects are caused by the action and occur at the same time and place.

Indirect effects are caused by the action, but occur at a later time and/or another place.

Cumulative effects are caused by other actions and processes, but may refer also to the collective effects on a resource, including direct and indirect effects of the action. The causal agents and spatial/temporal extent for considering cumulative effects varies according to the authority(ies) under which the Service is engaged in mitigation planning (*e.g.,* refer to the definitions of cumulative effects and cumulative impacts in ESA regulations and NEPA, respectively), and the Service will apply statute-specific definitions in the application of this policy.

Evaluation species. Fish, wildlife, and plant resources in the affected area that are selected for effects analysis and mitigation planning.

Habitat. An area with spatially identifiable physical, chemical, and biological attributes that supports one or more life-history processes for evaluation species. Mitigation planning should delineate habitat types in the affected area using a classification system that is applicable to both the region(s) of the affected area and the selected evaluation species in order to facilitate determinations of habitat scarcity, suitability, and importance.

Habitat value. An assessment of an affected habitat with respect to an evaluation species based on three attributes—scarcity, suitability, and importance—which define its conservation value to the evaluation species in the context of this policy. The three parameters are assessed independently but are sometimes correlated. For example, rare or unique habitat types of high suitability for evaluation species are also very likely of high importance in achieving conservation objectives.

Impacts. In the context of this policy, impacts are adverse effects relative to the affected resources.

Importance. The relative significance of the affected habitat, compared to other examples of a similar habitat type in the landscape context, to achieving conservation objectives for the evaluation species. Habitats of high importance are irreplaceable or difficult to replace, or are critical to evaluation species by virtue of their role in achieving conservation objectives within the landscape (*e.g.,* sustain core habitat areas, linkages, ecological functions). Areas containing habitats of high importance are generally, but not always, identified in conservation plans addressing resources under Service authorities (*e.g.,* in recovery plans) or when appropriate, under authorities of partnering entities (*e.g.,* in State wildlife action plans, Landscape Conservation Cooperative conservation ''blueprints,'' etc.).

Landscape. An area encompassing an interacting mosaic of ecosystems and human systems that is characterized by a set of common management concerns. The most relevant concerns to the Service and this policy are those associated with the conservation of species and their habitats. The landscape is not defined by the size of the area, but rather the interacting elements that are meaningful to the conservation objectives for the resources under consideration.

Landscape-scale approach. For the purposes of this policy, the landscape-scale approach applies the mitigation hierarchy for impacts to resources and their values, services, and functions at the relevant scale, however, narrow or broad, necessary to sustain, or otherwise achieve, established goals for those resources and their values, services, and functions. A landscape-scale approach should be used when developing and approving strategies or plans, reviewing projects, or issuing permits. The approach identifies the needs and baseline conditions of targeted resources and their values, services, and functions, reasonably foreseeable impacts, cumulative impacts of past and likely projected disturbance to those resources, and future disturbance trends. The approach then uses such information to identify priorities for avoidance, minimization, and

compensatory mitigation measures across that relevant area to provide the maximum benefit to the impacted resources and their values, services, and functions, with full consideration of the conditions of additionality and durability.

Landscape-scale strategies and plans. For the purposes of this policy, landscape-scale strategies and plans identify clear management objectives for targeted resources and their values, services, and functions at landscape-scales, as necessary, including across administrative boundaries, and employ the landscape-scale approach to identify, evaluate, and communicate how mitigation can best achieve those management objectives. Strategies serve to assist project applicants, stakeholders, and land managers in pre-planning as well as to inform NEPA analysis and decision making, including decisions to develop and approve plans, review projects, and issue permits. Land use planning processes provide opportunities for identifying, evaluating, and communicating mitigation in advance of anticipated land use activities. Consistent with their statutory authorities, land management agencies may develop landscape-scale strategies through the land use planning process, or incorporate relevant aspects of applicable and existing landscape-scale strategies into land use plans through the land use planning process.

Mitigation. In the context of this policy, the noun ''mitigation'' is a label for all types of measures (see Mitigation Types) that a proponent would implement toward achieving the Service's mitigation goal.

Mitigation hierarchy. The elements of mitigation, summarized as avoidance, minimization, and compensation, provide a sequenced approach to addressing the foreseeable impacts to resources and their values, services, and functions. First, impacts should be avoided by altering project design, location, or declining to authorize the project; then minimized through project modifications and permit conditions; and, generally, only then compensated for remaining unavoidable impacts after all appropriate and practicable avoidance and minimization measures have been applied.

Mitigation planning. The process of assessing the effects of an action and formulating mitigation measures that would achieve the mitigation planning goal.

Mitigation goal. The Service's goal for mitigation is to improve or, at minimum, maintain the current status of affected resources, as allowed by applicable statutory authority and consistent with the responsibilities of action proponents under such authority.

Mitigation types. General classes of methods for mitigating the impacts of an action (Council on Environmental Quality, 40 CFR 1508.20(a–e)), including:

(a) Avoid the impact altogether by not taking the action or parts of the action;

(b) minimize the impact by limiting the degree or magnitude of the action and its implementation;

(c) rectify the impact by repairing, rehabilitating, or restoring the affected environment;

(d) reduce or eliminate the impact over time by preservation and maintenance operations during the life of the action; and

(e) compensate for the impact by replacing or providing substitute resources or environments.

These five mitigation types, as enumerated by CEQ, are compatible with this policy; however, as a practical matter, the mitigation elements are categorized into three general types that form a sequence: avoidance, minimization, and compensation for remaining unavoidable (also known as residual) impacts. Section 5.6 (Mitigation Means and Measures) of this policy provides expanded definitions and examples for each of the mitigation types.

Practicable. Available and capable of being done after taking into consideration existing technology, logistics, and cost in light of a mitigation measure's beneficial value and a land use activity's overall purpose, scope, and scale.

Proponent. The agency(ies) proposing an action, and if applicable, any applicant(s) for agency funding or authorization to implement a proposed action.

Resources. Fish, wildlife, plants, and their habitats for which the Service has authority to recommend or require the mitigation of impacts resulting from proposed actions.

Scarcity. The relative spatial extent (*e.g.,* rare, common, or abundant) of the habitat type in the landscape context.

Suitability. The relative ability of the affected habitat to support one or more elements of the evaluation species' life history (reproduction, rearing, feeding, dispersal, migration, hibernation, or resting protected from disturbance, etc.) compared to other similar habitats in the landscape context. A habitat's ability to support an evaluation species may vary over time.

Unavoidable. An impact is unavoidable when an appropriate and practicable alternative to the proposed action that would not cause the impact is not available.

Appendix A. Authorities and Direction for Service Mitigation Recommendations

A. Relationship of Service Mitigation Policy to Other Policies, Regulations

This section is intended to describe the interaction of existing policies and regulations with this policy in agency processes. Descriptions regarding the application of mitigation concepts generally, and elements of this policy specifically, for each of the listed authorities follow.

1. The Bald and Golden Eagle Protection Act (16 U.S.C. 668–668d) (Eagle Act)

The Eagle Act prohibits take of bald eagles and golden eagles except pursuant to Federal regulations. The Eagle Act regulations at title 50, part 22 of the Code of Federal Regulations (CFR), define the ''take'' of an eagle to include the following actions: ''pursue, shoot, shoot at, poison, wound, kill, capture, trap, collect, destroy, molest, or disturb'' (§ 22.3).

Except for protecting eagle nests, the Eagle Act does not directly protect eagle habitat. However, because disturbing eagles is a violation of the Act, some activities within eagle habitat, including some habitat modification, can result in illegal take in the form of disturbance. ''Disturb'' is defined as ''to agitate or bother a bald or golden eagle to a degree that causes, or is likely to cause, based on the best scientific information available, (1) injury to an eagle, (2) a decrease in its productivity, by substantially interfering with normal breeding, feeding, or sheltering behavior, or (3) nest abandonment, by substantially interfering with normal breeding, feeding, or sheltering behavior.''

The Eagle Act allows the Secretary of the Interior to authorize certain otherwise prohibited activities through regulations. The Service is authorized to prescribe regulations permitting the taking, possession, and transportation of bald and golden eagles provided such permits are ''compatible with the preservation of the bald eagle or the golden eagle'' (16 U.S.C. 668a). Permits are issued for scientific and exhibition purposes; religious purposes of Native American tribes; falconry (golden eagles, only); depredation; protection of health and safety; removal of nests for resource development and recovery (golden eagles, only); and nonpurposeful (incidental) take.

The regulations for eagle nest take permits and eagle nonpurposeful take permits explicitly provide for mitigation, although the form and methods of mitigation are not specified, nor do the regulations contain criteria stipulating thresholds for when compensatory mitigation is required. The Eagle Act requires mitigation in the form of avoidance and minimization for these permits by restricting permitted take to circumstances where take is ''necessary.'' Though eagle habitat is not directly protected by the Eagle Act, the statute and implementing regulations allow the Service to require habitat preservation and/or enhancement as compensatory mitigation for eagle take.

Eagle take permits of all types are also subject to the requirement that any take that would exceed take thresholds established within geographic eagle management units (EMUs) must be offset by mitigation that will essentially replace each eagle taken. For example, if, under an eagle nonpurposeful take permit, a project is expected to kill an average of three eagles over a 5-year period, and take thresholds have been met in that EMU, the permittee must provide compensatory mitigation that prevents three eagles from being taken by another activity. At the time this Appendix A is being written, take thresholds for golden eagles are set at zero throughout the United States because golden eagle populations appear to be stable but not increasing, and as such unable to withstand additional take while still maintaining current numbers of breeding pairs over time. Accordingly, all permits for golden eagle take that would result in cumulative take within the EMU at levels above the 2009 baseline must incorporate compensatory mitigation. Permittees may be required to provide compensatory mitigation designed to improve conditions for eagles including habitat preservation or enhancement of prey base.

2. Clean Water Act (33 U.S.C. 1251 et seq.)

Several locations within the statute under section 404 describe the responsibilities and roles of the Service. The authority at section 404(m) is most directly relevant to the Service's engagement of Clean Water Act permitting processes to secure mitigation for impacts to aquatic resources nationwide and is routinely used by Ecological Services Field Offices. At section 404(m), the Secretary of the Army is required to notify the Secretary of the Interior, through the Service Director, that an individual permit application has been received or that the Secretary proposes to issue a general permit. The Service will submit any comments in writing to the Secretary of the Army (Corp of Engineers) within 90 days. The Service has the opportunity to engage several thousand Corps permit actions affecting aquatic habitats and wildlife annually and to assist the Corps of Engineers in developing permit terms that avoid, minimize, or compensate for permitted impacts. The Department of the Army has also entered into a Memorandum of Agreement with the Department of the Interior under Section 404(q) of the Clean Water Act. The current Memorandum of Agreement, signed in 1992, provides procedures for elevating national or regional issues relating to resources, policy, procedures, or regulation interpretation.

3. Endangered Species Act of 1973, as Amended (16 U.S.C. 1531 et seq.)

A primary purpose of the Endangered Species Act (ESA) of 1973 as amended (16 U.S.C. 1531 *et seq.*) is to conserve the ecosystems upon which species listed as endangered and threatened depend. Conserving listed species involves the use of all methods and procedures that are necessary for their recovery, which includes mitigating the impacts of actions to listed species and their habitats. All actions must comply with the applicable prohibitions against taking endangered animal species under ESA section 9 and taking threatened animal species under regulations promulgated through ESA section 4(d). Under ESA section 7(a)(2), Federal agencies must consult with the Service(s) to insure that any actions they fund, authorize, or carry out are not likely to jeopardize the continued existence of listed species or adversely modify designated critical habitat. Federal agencies, and any permit or license applicants, may be exempted from the prohibitions against incidental taking for actions that are not likely to jeopardize the continued existence of the species or result in the destruction or adverse modification of designated critical habitat, if the terms and conditions of the incidental take statement are implemented.

The Service may permit incidental taking resulting from a non-Federal action under ESA section 10(a)(1)(B) after approving the proponent's habitat conservation plan (HCP) under section 10(a)(2)(A). The HCP must specify the steps the permit applicant will take to minimize and mitigate such impacts, and the funding that will be available to implement such steps. The basis for issuing a section 10 permit includes a finding that the applicant will, to the maximum extent practicable, minimize and mitigate the impacts of incidental taking; and a finding that the taking will not appreciably reduce the likelihood of the survival and recovery of the species in the wild.

This mitigation policy applies to all actions that may affect ESA-protected resources except for conservation/recovery permits under section 10(a)(1)(A). The Service will recommend mitigation for impacts to listed species, designated critical habitat, and other species for which the Service has authorized mitigation responsibilities consistent with the guidance of this policy, which proponents may adopt as conservation measures to be added to the project descriptions of proposed actions. Such adoption may ensure that actions are not likely to jeopardize species or adversely modify designated critical habitat; however, such adoption alone does not constitute compliance with the ESA. Federal agencies must complete consultation per the requirements of section 7 to receive Service concurrence with ''may affect, not likely to adversely affect'' determinations, biological opinions for ''likely to adversely affect'' determinations, and incidental take statement terms and conditions. Proponents of actions that do not require Federal authorization or funding must complete the requirements under section 10(a)(2) to receive an incidental take permit. The mitigation planning under this policy applies to all species and their habitats for which the Service has authorities to recommend mitigation on a particular action, including listed species and critical habitat. Although this policy is intended, in part, to clarify the role of mitigation in endangered species conservation, nothing herein replaces, supersedes, or substitutes for the ESA implementing regulations.

All forms of mitigation are potential conservation measures of a proposed Federal action in the context of section 7 consultation and are factored into Service analyses of the effects of the action, including any voluntary mitigation measures proposed by a project proponent that are above and beyond those required by an action agency. Service regulations at 50 CFR 402.14(g)(8) affirm the need to consider ''any beneficial actions'' in formulating a biological opinion, including those ''taken prior to the initiation of consultation.'' Because jeopardy and adverse modification analyses weigh effects in the action area relative to the status of the species throughout its listed range and to the status of all designated critical habitat units, respectively, ''beneficial actions'' may also include proposed conservation measures for the affected species within its range but outside of the area of adverse effects (*e.g.,* compensation).

Mitigation measures included in proposed actions that avoid and minimize the likelihood of adverse effects and incidental take are also relevant to the Service's concurrence with ''may affect, not likely to adversely affect'' determinations through informal consultation. All mitigation measures included in proposed actions that benefit listed species and/or designated critical habitat, including compensatory measures, are relevant to jeopardy and adverse modification conclusions in Service biological opinions.

Likewise, the Service may apply all forms of mitigation, consistent with the guidance of this policy, in formulating a reasonable and prudent alternative that would avoid jeopardy/adverse modification, provided that it is also consistent with the regulatory definition of a reasonable and prudent alternative at 50 CFR 402.02. It is preferable to avoid or minimize impacts to listed species or critical habitat before rectifying, reducing over time, or compensating for such impacts. Under some limited circumstances, however, the latter forms of mitigation may provide all or part of the means to achieving the best possible conservation outcome for listed species consistent with the purpose-, authority-, and feasibility-requirements of a reasonable and prudent alternative.

For Federal actions that are not likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of habitat, the Service may provide a statement specifying those reasonable and prudent measures that are necessary or appropriate to minimize the impacts of taking incidental to such actions on the affected listed species. No proposed mitigation measures relieve an action proponent of the obligation to obtain incidental take exemption through an incidental take statement (Federal actions) or authorization through an incidental take permit (non-Federal actions), as appropriate, for unavoidable incidental take that may result from a proposed action.

4. Executive Order 13186 (E.O. 13186), Responsibilities of Federal Agencies To Protect Migratory Birds

E.O. 13186 directs Federal departments and agencies to avoid or minimize adverse impacts on ''migratory bird resources,'' defined as ''migratory birds and the habitats upon which they depend.'' These acts of

avian protection and conservation are implemented under the auspices of the MBTA, the Eagle Act, the Fish and Wildlife Coordination Act (16 U.S.C. 661–666c), the Endangered Species Act, the National Environmental Policy Act, and ''other established environmental review process'' (Section 3(e)(6)). Additionally, E.O. 13186 directs Federal agencies whose activities will likely result in measurable negative effects on migratory bird populations to collaboratively develop and implement an MOU with the Service that promotes the conservation of migratory bird populations. These MOUs can clarify how an agency can mitigate the effects of impacts and monitor implemented conservation measures. MOUs can also define how appropriate corrective measures can be implemented when needed, as well as what proactive conservation actions or partnerships can be formed to advance bird conservation, given the agency's existing mission and mandate.

The Service policy regarding its responsibility to E.O. 13186 (720 FW 2) states ''all Service employees should: A. Implement their mission-related activities and responsibilities in a way that furthers the conservation of migratory birds and minimizes and avoids the potential adverse effects of migratory bird take, with the goal of eliminating take'' (22.A.). The policy also stipulates that the Service will support the conservation intent of the migratory bird conventions by: integrating migratory bird conservation measures into our activities, including measures to avoid or minimize adverse impacts on migratory bird resources; restore and enhance the habitat of migratory birds; and prevent or abate the pollution or detrimental alteration of the environment for the benefit of migratory birds.

5. Executive Order 13653 (E.O. 13653), Preparing the United States for the Impact of Climate Change

E.O. 13653 directs Federal agencies to improve the Nation's preparedness and resilience to climate change impacts. The agencies are to promote: (1) Engaged and strong partnerships and information sharing at all levels of government; (2) risk-informed decision-making and the tools to facilitate it; (3) adaptive learning, in which experiences serve as opportunities to inform and adjust future actions; and (4) preparedness planning.

Among the provisions under section 3, *Managing Lands and Waters for Climate Preparedness and Resilience,* is this: ''agencies shall, where possible, focus on program and policy adjustments that promote the dual goals of greater climate resilience and carbon sequestration, or other reductions to the sources of climate change . . . [a]gencies shall build on efforts already completed or underway . . . as well as recent interagency climate adaptation strategies.'' Section 5 specifies that agencies shall develop or continue to develop, implement, and update comprehensive plans that integrate consideration of climate change into agency operations and overall mission objectives.

The *Priority Agenda: Enhancing The Climate Resilience of American's Natural Resources* (October 2014) called for in E.O. 13653, includes provisions to develop and provide decision support tools for ''climate-smart natural resource management'' that will improve the ability of agencies and landowners to manage for resilience to climate change impacts.

The Service policy on climate change adaptation (056 FW 1) states that the Service will ''effectively and efficiently incorporate and implement climate change adaptation measures into the Service's mission, programs, and operations.'' This includes using the best available science to coordinate an appropriate adaptive response to impacts on fish, wildlife, plants, and their habitats. The policy also specifically calls for delivering landscape conservation actions that build resilience or support the ability of fish, wildlife, and plants to adapt to climate change.

6. Federal Power Act (16 U.S.C. 791–828c) (FPA)

The Federal Energy Regulatory Commission (FERC) authorizes non-Federal hydropower projects pursuant to the FPA. The Service's roles in hydropower project review are primarily defined by the FPA, as amended in 1986 by the Electric Consumers Protection Act, that explicitly ascribes those roles to the Service. The Service has mandatory conditioning authority for projects on National Wildlife Refuge System lands under section 4(e) and to prescribe fish passage to enhance and protect native fish runs under section 18. Under section 10(j), FERC is required to include license conditions that are based on recommendations made pursuant to the Fish and Wildlife Coordination Act by states, NOAA, and the Service for the adequate and equitable protection, mitigation, and enhancement of fish, wildlife, and their habitats.

7. Fish and Wildlife Conservation Act (16 U.S.C. 2901–2912)

Specifically, Federal Conservation of Migratory Nongame Birds (16 U.S.C. 2912) implicitly provides for mitigation by requiring the Service to ''identify the effects of environmental changes and human activities on species, subspecies, and populations of all migratory nongame birds'' (section 2912(2)); ''identify conservation actions to assure that species, subspecies, and populations of migratory nongame birds . . . do not reach the point at which the measures provided pursuant to the Endangered Species Act of 1973, as amended (16 U.S.C. 1531–1543) become necessary'' (section 2912(4)); and ''identify lands and waters in the United States and other nations in the Western Hemisphere whose protection, management, or acquisition will foster the conservation of species, subspecies, and populations of migratory nongame birds . . . .'' (section 2912(5)).

8. Fish and Wildlife Coordination Act (16 U.S.C. 661–667e)(FWCA)

The FWCA requires Federal agencies developing water-related projects to consult with the Service, NOAA, and the States regarding fish and wildlife impacts. The FWCA establishes fish and wildlife conservation as a coequal objective of all federally funded, permitted, or licensed water-related development projects. Federal action agencies are to include justifiable means and measures for fish and wildlife, and the Service's mitigation and enhancement recommendations are to be given full and equal consideration with other project purposes. The Service's mitigation recommendations may include measures addressing a broad set of habitats beyond the aquatic impacts triggering the FWCA and taxa beyond those covered by other resource laws. Action agencies are not bound by the FWCA to implement Service conservation recommendations in their entirety.

9. Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1361 et seq.) (MMPA)

The MMPA prohibits the take (*i.e.,* hunting, killing, capture, and/or harassment) of marine mammals and enacts a moratorium on the import, export, and sale of marine mammal parts and products. There are exemptions and exceptions to the prohibitions. For example, under section 101(b), Alaskan Natives may hunt marine mammals for subsistence purposes and may possess, transport, and sell marine mammal parts and products.

In addition, section 101(a)(5) allows for the authorization of incidental, but not intentional, take of small numbers of marine mammals by U.S. citizens while engaged in a specified activity (other than commercial fishing) within a specified geographical region, provided certain findings are made. Specifically, the Service must make a finding that the total of such taking will have a negligible impact on the marine mammal species and will not have an unmitigable adverse impact on the availability of these species for subsistence uses. Negligible impact is defined at 50 CFR 18.27(c) as ''an impact resulting from the specified activity that cannot be reasonably expected to, and is not reasonably likely to, adversely affect the species or stock through effects on annual rates of recruitment or survival.'' Unmitigable adverse impact, which is also defined at 50 CFR 18.27(c), means ''an impact resulting from the specified activity that is likely to reduce the availability of the species to a level insufficient for a harvest to meet subsistence needs by (i) causing the marine mammals to abandon or avoid hunting areas, (ii) directly displacing subsistence users, or (iii) placing physical barriers between the marine mammals and the subsistence hunters; and (2) cannot be sufficiently mitigated by other measures to increase the availability of marine mammals to allow subsistence needs to be met.''

Section 101(a)(5)(A) provides for the promulgation of Incidental Take Regulations (ITRs), which can be issued for a period of up to 5 years. The ITRs set forth permissible methods of taking pursuant to the activity and other means of affecting the least practicable adverse impact on the species or stock and its habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance. In addition, ITRs include requirements pertaining to the monitoring and reporting of such takings. Under the ITRs, a U.S. citizen may request

a Letter of Authorization (LOA) for activities proposed in accordance with the ITRs. The Service evaluates each LOA request based on the specific activity and geographic location, and determines whether the level of taking is consistent with the findings made for the total taking allowable under the applicable ITRs. If so, the Service may issue an LOA for the project and will specify the period of validity and any additional terms and conditions appropriate to the request, including mitigation measures designed to minimize interactions with, and impacts to, marine mammals. The LOA will also specify monitoring and reporting requirements to evaluate the level and impact of any taking. Depending on the nature, location, and timing of a proposed activity, the Service may require applicants to consult with potentially affected subsistence communities in Alaska and develop additional mitigation measures to address potential impacts to subsistence users. Regulations specific to LOAs are codified at 50 CFR 18.27(f).

Section 101(a)(5)(D) established an expedited process to request authorization for the incidental, but not intentional, take of small numbers of marine mammals for a period of not more than 1 year if the taking will be limited to harassment, *i.e.,* Incidental Harassment Authorizations (IHAs). Harassment is defined in section 3 of the MMPA (16 U.S.C. 1362). For activities other than military readiness activities or scientific research conducted by or on behalf of the Federal Government, harassment means ''any act of pursuit, torment, or annoyance which (i) has the potential to injure a marine mammal or marine mammal stock in the wild'' (the MMPA calls this Level A harassment) ''or (ii) has the potential to disturb a marine mammal or marine mammal stock in the wild by causing disruption of behavioral patterns, including, but not limited to migration, breathing, nursing, breeding, feeding, or sheltering'' (the MMPA calls this Level B harassment). There is a separate definition of harassment applied in the case of a military readiness activity or a scientific research activity conducted by or on behalf of the Federal Government. The IHA prescribes permissible methods of taking by harassment and includes other means of achieving the least practicable impact on marine mammal species or stocks and their habitats, paying particular attention to rookeries, mating grounds, and areas of similar significance. In addition, as appropriate, the IHA will include measures that are necessary to ensure no unmitigable adverse impact on the availability of the species or stock for subsistence purposes in Alaska. IHAs also specify monitoring and reporting requirements pertaining to the taking by harassment.

ITRs and IHAs can provide considerable conservation and management benefits to covered marine mammals. The Service shall recommend mitigation for impacts to species covered by the MMPA that are under its jurisdiction consistent with the guidance of this policy. Proponents may adopt these recommendations as components of proposed actions. However, such adoption itself does not constitute full compliance with the MMPA.

10. Migratory Bird Treaty Act (16 U.S.C. 703–712) (MBTA)

The MBTA does not allow the take of migratory birds without a permit or other regulatory authorization (*e.g.,* rule, depredation order). The Service has express authority to issue permits for purposeful take and currently issues several types of permits for purposeful take of individuals (*e.g.,* hunting, depredation, scientific collection). Hunting permits do not require the mitigation hierarchy be enacted; rather, the Service sets annual regulations that limit harvest to ensure levels harvested do not diminish waterfowl breeding populations. For purposeful take permits that are not covered in these annual regulations (*e.g.,* depredation, scientific collection), there is an expectation that take be avoided and minimized to the maximum extent practicable as a condition of the take authorization process. Compensation and offsets are not required under these purposeful take permits, but can be accepted.

The Service has implied authority to permit incidental take of migratory birds, though incidental take has only been authorized in limited situations (*e.g.,* Department of Defense Readiness Rule and the NOAA Fisheries Special Purpose Permit). In all situations, permitted or unpermitted, there is an expectation that take be avoided and minimized to the maximum extent practicable, and voluntary offsets can be employed to this end. However, the Service cannot legally require or accept compensatory mitigation for unpermitted, and thus illegal, take of individuals. While action proponents are expected to reduce impacts to migratory bird habitat, such impacts are not regulated under MBTA. As a result, action proponents are allowed to use the full mitigation hierarchy to manage impacts to their habitats, regardless of whether or not a permit for take of individuals is in place. Assessments of action effects should examine direct, indirect, and cumulative impacts to migratory bird habitats, as habitat losses have been identified as a critical factor in the decline of many migratory bird species.

11. National Environmental Policy Act (42 U.S.C. 4321 et seq.) (NEPA)

NEPA requires Federal agencies to integrate environmental values into decision making processes by considering impacts of their proposed actions and reasonable alternatives. Agencies disclose findings through Environmental Assessments or a detailed Environmental Impact Statement and are required to identify and include all relevant and reasonable mitigation measures that could improve the action. The Council on Environmental Quality's implementing regulations under NEPA define mitigation as a sequence, where mitigation begins with avoidance of impacts; followed by minimization of the degree or magnitude of impacts; rectification of impacts through repair, restoration, or rehabilitation; reducing impacts over time during the life of the action; and lastly, compensation for impacts by providing replacement resources. Effective mitigation through this ordered approach starts at the beginning of the NEPA process, not at the end. Implementing regulations require that the Service be notified of all major Federal actions affecting fish and wildlife and our recommendations solicited. Engaging this process allows the Service to provide comments and recommendations for mitigation of fish and wildlife impacts.

12. National Wildlife Refuge Mitigation Policy

The Service's Final Policy on the National Wildlife Refuge System and Compensatory Mitigation under the section 10/404 Program (64 FR 49229–49234, September 10, 1999) (Refuge Mitigation Policy) published in 1999 establishes guidelines for the use of Refuge lands for siting compensatory mitigation for impacts permitted through section 404 of the Clean Water Act (CWA) and section 10 of the Rivers and Harbors Act (RHA). The Refuge Mitigation Policy clarifies that siting mitigation for off-Refuge impacts on Refuge lands is appropriate only in limited and exceptional circumstances. Mitigation banks may not be sited on Refuge lands, but the Service may add closed banks to the Refuge system if specific criteria are met. The Refuge Mitigation Policy, which explicitly addresses only compensatory mitigation under the CWA and RHA, remains in effect and is unaltered by this policy. However, the Service will evaluate all proposals for using Refuge lands as sites for other compensatory mitigation purposes using the criteria and procedures established for aquatic resources in the Refuge Mitigation Policy (*e.g.,* to locate compensatory mitigation on Refuge property for off-Refuge impacts to endangered or threatened species).

13. Natural Resource Damage Assessment and Restoration (NRDAR)

This policy applies to actions for which the Service is a participating bureau, supporting the Department of the Interior, during activities associated with assessment of injuries to natural resources caused by oil spills or releases of hazardous materials, under the Oil Pollution Act (33 U.S.C. 2701 *et seq.*) and the Comprehensive Environmental Response, Compensation and Liability Act (42 U.S.C. 9601), as amended by Public Law 99–499. When a release of hazardous materials or an oil spill injures natural resources under the jurisdiction of State, tribal, and Federal agencies, these governments quantify the injuries to determine appropriate restoration to compensate the public for losses of those resources or their services.

A restoration settlement, in the form of damages provided through a settlement document, is usually determined by quantifying the type and amount of restoration necessary to offset the injury caused by the spill or release. The type of restoration conducted depends on the resources injured by the release (*e.g.,* marine habitats, ground water, or biological resources (fish, birds)).

The NRDAR program may impose constraints associated with the Service's Mitigation Policy. Jurisdiction over natural resources varies by agency, and the restoration portion of a given settlement is often resolved jointly with other Federal/

State/tribal trustees, thus requiring their approval of allocation of funds for restoration projects. This policy will be used by the Service to guide restoration projects that benefit Service resources and as one mechanism to direct restoration planning toward goals common to other trustees. Thus, the policy maintains the flexibility to implement the appropriate restoration to compensate for the injured resources under the jurisdiction of multiple government agencies. This policy does not seek to inhibit discussions aimed at achieving settlement, rather it seeks to offer flexibility while defining compensatory projects by providing support for weighing or modifying project elements to reach Service goals.

B. Additional Legislative Authorities

1. Clean Air Act; 42 U.S.C. 7401 *et seq.,* as amended (See *http://www.fws.gov/refuges/airquality/permits.html*)
2. Marine Protection, Research, and Sanctuaries Act; 16 U.S.C. 1431 *et seq.* and 33 U.S.C. 1401 *et seq.*
3. Resource Conservation and Recovery Act; 42 U.S.C. 6901 *et seq.*
4. Shore Protection Act; 33 U.S.C. 2601 *et seq.*
5. Coastal Zone Management Act; 16 U.S.C. 1451 *et seq.*
6. Coastal Barrier Resources Act; 16 U.S.C. 3501
7. Surface Mining Control and Reclamation Act; 30 U.S.C. 1201 *et seq.*
8. National Wildlife Refuge System Administration Act; 16 U.S.C. 668dd, as amended
9. National Historic Preservation Act; 16 U.S.C. 470f
10. Pittman-Roberts Wildlife Restoration Act; 16 U.S.C. 669–669k
11. Dingell-Johnson Sport Fish Restoration Act; 16 U.S.C. 777–777n, except 777 e–1 and g–1
12. Federal Land and Policy Management Act, 43 U.S.C. 1701 *et seq.*

C. Implementing Regulations

1. National Environmental Policy Act (NEPA), 40 CFR part 1508, 42 U.S.C. 55
2. Marine Mammal Protection Act (MMPA), 50 CFR part 18, 16 U.S.C. 1361 *et seq.*
3. Migratory Bird Treaty Act (MBTA), 50 CFR part 21, 16 U.S.C. 703 *et seq.*
4. Bald and Golden Eagle Protection Act (Eagle Act), 50 CFR part 22, 16 U.S.C. 668 *et seq.*
5. Guidelines for Wetlands Protection, 33 CFR parts 320 and 332, 40 CFR part 230
6. Compensatory Mitigation for Losses of Aquatic Resources, 33 CFR parts 325 and 332 (USACE) and 40 CFR part 230 (EPA), 33 U.S.C. 1344
7. Natural Resource Damage Assessments (OPA), 15 CFR part 990, 33 U.S.C. 2701 *et seq.*
8. Natural Resource Damage Assessments (CERCLA), 43 CFR part 11, 42 U.S.C. 9601
9. Endangered Species Act of 1973, as amended; 50 CFR parts 13, 17 (specifically §§ 17.22, 17.32, 17.50), part 402; 16 U.S.C. 1531 *et seq.*

D. Executive Orders

1. Executive Order 13186, Responsibilities of Federal Agencies to Protect Migratory Birds
2. Executive Order 12114, Environmental Effects Abroad of Major Federal Actions, January 4, 1979
3. Executive Order 11988, Floodplain Management, May 24, 1977
4. Executive Order 11990, Protection of Wetlands, May 24, 1977
5. Executive Order 12898, Environmental Justice for Low Income and Minority Populations, February 11, 1994
6. Executive Order 13514, Federal Leadership in Environmental, Energy, and Economic Performance, October 5, 2009
7. Executive Order 13604, Improving Performance of Federal Permitting and Review of Infrastructure Projects, March 22, 2012

E. Council on Environmental Quality (CEQ) Policy and Guidance

1. Guidance Regarding NEPA Regulations (48 FR 34236, July 28, 1983)
2. Designation of Non-Federal Agencies to be Cooperating Agencies in Implementing the Procedural Requirements of the National Environmental Policy Act (40 CFR 1508.5, July 28, 1999)
3. Cooperating Agencies in Implementing the Procedural Requirements of the National Environmental Policy Act (January 30, 2002)
4. Memorandum, ''Appropriate Use of Mitigation and Monitoring and Clarifying the Appropriate Use of Mitigated Findings of No Significant Impact'' (January 14, 2011)

F. Department of the Interior Policy and Guidance

1. Department of the Interior National Environmental Policy Act Procedures, 516 DM 1–7
2. Secretarial Order 3330, Improving Mitigation Policies and Practices of the Department of the Interior (October 31, 2013)
3. Secretarial Order 3206, American Indian Tribal Rights, Federal-Tribal Trust Responsibilities, and the Endangered Species Act (June 5, 1997)
4. Department of the Interior Climate Change Adaptation Policy, 523 DM 1

G. U.S. Fish and Wildlife Service (USFWS) Policy and Guidance

1. Service Responsibilities to Protect Migratory Birds, 720 FW 2
2. Final Policy on the National Wildlife Refuge System and Compensatory Mitigation under the Section 10/404 Program, 64 FR 49229–49234, September 10, 1999
3. Habitat Conservation Planning and Incidental Take Permit Processing Handbook, 61 FR 63854, 1996
4. USFWS National Environmental Policy Act Reference Handbook, 505 FW 1.7 and 550 FW 1
5. Endangered Species Act Habitat Conservation Planning Handbook (with NMFS), 1996
6. Endangered Species Act Consultation Handbook (with NMFS), 1998
7. Inter-agency Memorandum of Agreement Regarding Oil Spill Planning and Response Activities Under the Federal Water Pollution Control Act's National Oil and Hazardous Substances Pollution Contingency Plan and the Endangered Species Act, 2002
8. Guidance for the Establishment, Use, and Operation of Conservation Banking, 2003
9. Endangered and Threatened Wildlife and Plants; Recovery Crediting Guidance, 2008
10. Service Climate Change Adaptation Policy, 056 FW 1

H. Other Agency Policy, Guidance, and Actions Relevant to Service Activities

1. Memorandum of Agreement Between The Department of the Army and The Environmental Protection Agency, The Determination of Mitigation under the Clean Water Act Section 404(b)(1) Guidelines, 1990
2. Federal Highway Administration, Consideration of Wetlands in the Planning of Federal Aid Highways, 1990
3. Clean Water Act Section 404(q) Memorandum of Agreement Between the Department of the Interior and the Department of the Army, 1992
4. Interagency Agreement between the National Park Service, Fish and Wildlife Service, Bureau of Land Management, and the Federal Aviation Administration Regarding Low-Level Flying Aircraft Over Natural Resource Areas, 1993
5. USFWS Memorandum from Acting Director to Regional Directors, Regarding ''Partners for Fish and Wildlife Program and NEPA Compliance,'' 2002
6. Agreement between the U.S. Fish and Wildlife Service and the U.S. Army Corps of Engineers for Conducting Fish and Wildlife Coordination Act Activities, 2003
7. Memorandum of Agreement Between the U.S. Fish and Wildlife Service and the U.S. Army Corps of Engineers, 2003
8. Partnership Agreement between the U.S. Army Corps of Engineers and the U.S. Fish and Wildlife Service for Water Resources and Fish and Wildlife, 2003
9. Memoranda of understanding with nine Federal agencies, under E.O. 13186, Responsibilities of Federal Agencies to Protect Migratory Birds (*http://www.fws.gov/migratorybirds/PartnershipsAndIniatives.html*)

Appendix B. Service Mitigation Policy and NEPA

A. Mitigation in Environmental Review Processes

NEPA was enacted to promote efforts to prevent or eliminate damage to the environment and biosphere (42 U.S.C. 4321). The NEPA process is intended to help officials make decisions based on an understanding of environmental consequences and take actions that protect, restore, and enhance the environment (40 CFR part 1501). It requires consideration of the impacts from connected, cumulative, and similar actions, and their relationship to the maintenance and enhancement of long-term productivity (42 U.S.C. 4332). Mitigation measures should be developed that effectively and efficiently address the

predicted and actual impacts, relative to the ability to maintain and enhance long-term productivity. The consideration of mitigation (type, timing, degree, etc.) should be consistent with and based upon the evaluation of direct, indirect, and cumulative impacts. The Service should also consider and encourage public involvement in development of mitigation planning, including components such as compliance and effectiveness monitoring, and adaptive management processes.

Consistent with January 14, 2011 CEQ Memorandum: Appropriate Use of Mitigation and Monitoring and Clarifying the Appropriate Use of Mitigated Findings of No Significant Impacts, Service-proposed actions should incorporate measures to avoid, minimize, rectify, reduce, and compensate for impacts into initial proposal designs and described as part of the action. Measures to achieve net gain or no-net-loss outcomes have the greatest potential to achieve environmentally preferred outcomes that are encouraged by the memorandum, and measures to achieve net gain outcomes have the greatest potential to enhance long-term productivity. We should analyze mitigation measures considered, but not incorporated into the proposed action, as one or more alternatives. For illustrative purposes, our NEPA documents may address mitigation alternatives or consider mitigation measures that the Service does not have legal authority to implement. However, the Service should not commit to mitigation alternatives or measures considered or analyzed without sufficient legal authorities or sufficient resources to perform or ensure the effectiveness of the mitigation (CEQ 2011). The Service should monitor the compliance and effectiveness of our mitigation commitments. For applicant-driven actions, some or most of the responsibility for mitigation monitoring may lie with the applicant; however, the Service retains the ultimate responsibility to ensure that monitoring is occurring when needed and that the results of monitoring are properly considered in an adaptive management framework.

When carrying out its responsibilities under NEPA, the Service will apply the mitigation meanings and sequence in the NEPA regulations (40 CFR 1508.20). In particular, the Service will retain the ability to distinguish between:

- Minimizing impacts by limiting the degree or magnitude of the action and its implementation;
- rectifying the impact by repairing, rehabilitating, or restoring the affected environment; and
- reducing or eliminating the impact over time by preservation and maintenance operations during the life of the action.

Minimizing impacts under NEPA is commonly applied at the planning design stage, prior to the action (and impacts) occurring. Rectification and reduction over time are measures applied after the action is implemented (even though they may be included in the plan). Therefore, under NEPA, there are often very different temporal scopes between minimization measures and those for rectification and reduction over time. These temporal differences can be important for developing and evaluating alternatives, analyzing indirect and cumulative impacts, and for designing and implementing effectiveness and compliance monitoring. Therefore, the Service will retain the ability to distinguish between these three mitigation types when doing so will improve the ability to take the requisite NEPA ''hard look'' at potential environmental impacts and reasonable alternatives to proposed actions.

Other statutes besides NEPA that compel the Service to address the possible environmental impacts of mitigation activities for fish and wildlife resources commonly include the National Historic Preservation Act of 1996 (NHPA) (16 U.S.C 470 *et seq.*), as amended in 1992, the Federal Water Pollution Control Act (Clean Water Act) (33 U.S.C. 1251–1376), Fish and Wildlife Coordination Act (16 U.S.C 661–667(e)), as amended (FWCA), and the Clean Air Act (42 U.S.C. 7401–7661). Service mitigation decisions should also comply with all applicable Executive Orders, including E.O. 13514, Federal Leadership in Environmental, Energy, and Economic Performance (October 5, 2009), E.O. 13653, Preparing the United States for the Impacts of Climate Change (November 1, 2013), and E.O. 12898, Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations. DOI Environmental Compliance Memorandum (ECM) 95–3 provides additional direction regarding responsibilities for addressing environmental justice under NEPA, including the equity of benefits and risks distribution.

B. Efficient Mitigation Planning

The CEQ Regulations Implementing NEPA include provisions to reduce paperwork (§ 1500.4), delay (§ 1505.5), duplication with State and local procedures (§ 1506.2), and combine documents in compliance with NEPA. A key component of the provisions to reduce paperwork directs Federal agencies to use environmental impact statements for programs, policies, or plans, and to tier from statements of broad scope to those of narrower scope, in order to eliminate repetitive discussions of the same issues (§ 1501.1(i), 1502.4, and 1502.20). To the fullest extent possible, the Service should coordinate with State, tribal, local, and other Federal entities to conduct joint mitigation planning, research, and environmental review processes. Mitigation planning can also provide efficiencies when it is used to reduce the impacts of a proposed project to the degree it eliminates significant impacts and avoids the need for an Environmental Impact Statement. When using this approach, employing a mitigated Finding of No Significant Impact (FONSI), the Service should ensure consistency with the aforementioned January 14, 2011, CEQ memorandum.

Use of this mitigation policy will help focus our NEPA discussion on issues for fish, wildlife, plants, and their habitats, and will avoid unnecessarily lengthy background information. When appropriate, the Service should use the process for establishing evaluation species and resource categories to concentrate our environmental analyses on relevant and significant issues.

Programmatic NEPA analyses can establish standards for consideration and implementation of mitigation, and can more effectively address cumulative impacts. To ensure that landscape-scale mitigation planning is effectively implemented and meets conservation goals, the Service should seek and consider collaborative opportunities to conduct programmatic NEPA decision-making processes on Service actions that are similar in timing, impacts, alternatives, resources, and mitigation. Existing landscape-scale conservation and mitigation plans that have already undergone a NEPA process will provide efficiencies for Federal actions taken on a project-specific basis and will also better address potential cumulative impacts. However, the Service may incorporate plans or components of plans by reference (40 CFR 1502.21), while addressing impacts from plans or components within the NEPA process on the Service action.

C. NEPA and Tribal Trust Responsibilities

NEPA also provides a process through which all Tribal Trust responsibilities can be addressed simultaneous to consultation, but care should be taken to ensure that culturally sensitive information is not disclosed. Resources that may be impacted by Service actions or mitigation measures include culturally significant or sacred landscapes, species associated with those landscapes, or species that are separately considered culturally significant or sacred. The Service should coordinate or consult with affected tribes to develop methods for evaluating impacts, significance criteria, and meaningful mitigation to sacred or culturally significant species and their locales. Because climate change has been identified as an Environmental Justice (EJ) issue for tribes, adverse climate change-related effects to culturally significant or sacred landscapes or species may be cumulatively greater, and may indicate the need for a separate EJ analysis. Affected tribes can be those for which the locale of the action or landscape mitigation planning lies within traditional homelands and can include traditional migration areas. The final determination of whether a tribe is affected is made by the tribe, and should be ascertained during consultation or a coordination process. When government-to-government consultation takes place, the consultation process will be guided by the Service Tribal Consultation Handbook.

The Service has overarching Tribal Trust Doctrine responsibilities under the Eagle Act, the National Historic Preservation Act (NHPA), the American Indian Religious Freedom Act (AIRFA) (42 U.S.C. 1996), Religious Freedom Restoration Act of 1993 (RFRA) (42 U.S.C. 2000bb *et seq.*), Secretarial Order 3206, American Indian Tribal Rights, Federal-Tribal Trust Responsibilities, the Endangered Species Act (June 5, 1997), Executive Order 13007, Indian Sacred Sites (61 FR 26771, May 29, 1996), and the USFWS Native American Policy. Government-wide statutes with requirements to consult with tribes include the Archeological Resources Protection Act of 1979 (ARPA) (16 U.S.C.

470aa–mm), the Native American Graves Protection and Repatriation Act (NAGPRA) (25 U.S.C. 3001 et. seq.), and AIRFA. Regulations with requirements to consult include NAGPRA, NHPA, and NEPA.

D. Integrating Mitigation Policy Into the NEPA Process

When the Service is the lead or co-lead Federal agency for NEPA compliance, the mitigation policy may inform several components of the NEPA process and make it more effective and more efficient in conserving the affected Federal trust resources. This section discusses the role of the mitigation policy in Service decision making under NEPA.

Scoping

The Service should use internal and external scoping to help identify appropriate evaluation species, obtain information about the relative scarcity, suitability, and importance of affected habitats for resource category assignments, identify issues associated with these species and habitats, and identify issues associated with other affected resources. Climate change vulnerability assessments can be a valuable tool for identifying or screening new evaluation species. The Service should coordinate external scoping with agencies having special expertise or jurisdiction by law for the affected resources.

Purpose and Need

The Purpose and Need statement of the NEPA document should incorporate relevant conservation objectives for evaluation species and their habitats, and the need to ensure either a net gain or no-net-loss. Because the statement of Purpose and Need frames the development of the Proposed Action and Alternatives, including conservation objectives from the beginning, it steers action proposals away from impacts that may otherwise necessitate mitigation. Addressing conservation objectives in the purpose statement initiates a planning process in which the proposed action and all reasonable alternatives evaluated necessarily include appropriate conservation measures, differing in type or degree, and avoids presenting decision makers with a choice between a ''conservation alternative'' and a ''no conservation alternative.''

Affected Environment

The Affected Environment discussion should focus on significant environmental issues associated with evaluation species and their habitats and highlight resource vulnerabilities that may require mitigation features in the project design. This section should document the relative scarcity, suitability, and importance of affected habitats, along with the sensitivity and status of the species and habitats. It should identify relevant temporal and spatial scales for each resource and the appropriate indicators of effects and units of measurement for evaluating mitigation features. This section should also identify habitats for evaluation species that are currently degraded but have a moderate to high potential for restoration or improvement.

Significance Criteria

Explicit significance criteria provide the benchmarks or standards for evaluating effects under NEPA. Potentially significant impacts to resources require decision making supported by an Environmental Impact Statement. Determining significance considers both the context and intensity of effects. For resources covered by this mitigation policy, the sensitivity and status of affected species, and the relative scarcity, suitability, and importance of affected habitats, provide the context component of significance criteria. Measures of the severity of effects (degree, duration, spatial extent, etc.) provide the intensity component of significance criteria. Significance criteria may help identify appropriate levels and types of mitigation; however, the Service should consider mitigation for impacts that do not exceed thresholds for significance as well as those that do.

Analysis of Environmental Consequences

The analysis of Environmental Consequences should address the relationship of effects to the maintenance and enhancement of long-term productivity (40 CFR 1502.16), and include the timing and duration of direct, indirect, and cumulative effects to resources, short-term versus long-term effects (adverse and beneficial), and how the timing and duration of mitigation would influence net effects over time. The Service's net gain goal for fish and wildlife resources under this policy applies to the full planning horizon of a proposed action. Guidance under section V.B.3 (Assessment Principles) of this policy supplements existing Service, Department, and government-wide guidance for the Service's environmental consequences analyses for affected fish and wildlife resources under NEPA.

Cumulative Effects Analyses

The long-term benefits of mitigation measures, whether on-site or off-site relative to the proposed action, often depend on their placement in the landscape relative to other environmental resources and stressors. Therefore, cumulative effects analyses, including the effects of climate change, are especially important to consider in designing mitigation measures for fish and wildlife resources. Cumulative effects analyses should include consideration of direct and indirect effects of climate change and should incorporate mitigation measures to address altered conditions. Cumulative effects are doubly important in actions affecting species in decline, such as ESA-listed or candidate species, marine mammals, and Birds of Conservation Concern, for which the Service should design mitigation that will improve upon existing conditions and offset as much as practicable reasonably foreseeable adverse cumulative effects. Also, to the extent practicable, cumulative effects analyses should address the synergistic effects of multiple foreseeable resource stressors. For example, in parts of some western States, the combination of climate change, invasive grasses, and nitrogen deposition may substantially increase fire frequency and intensity, adversely affecting some resources to a greater degree than the sum of these stressors considered independently.

Analysis of Climate Change

The analyses of climate change effects should address effects to and changes for the evaluation species, resource categories, mitigation measures, and the potential for changes in the effects of mitigation measures. Anticipated changes may result in the need to choose different or additional evaluation species and habitat, at different points in time.

Decision Documents

Mitigation measures should be included as commitments within a Record of Decision (ROD) for an EIS, and within a mitigated FONSI. The decision documents should clearly identify: Measures to achieve outcomes of no net loss or net gain; the types of mitigation measures adopted for each evaluation species or suite of species; the spatial and temporal application and duration of the measures; compliance and effectiveness monitoring; criteria for remedial action; and unmitigable residual effects.

Appendix C. Compenstory Mitigation in Financial Assistance Awards Approved or Administered by the U.S. Fish and Wildlife Service

The basic authority for Federal financial assistance is in the Federal Grant and Cooperative Agreement Act of 1977 (31 U.S.C. 6301 *et seq.*). It distinguishes financial assistance from procurement, and explains when to use a grant or a cooperative agreement as an instrument of financial assistance. Regulations at 2 CFR part 200 provide Government-wide rules for managing financial assistance awards. Each of the Service's 60 financial assistance programs has at least one statutory authority, which are listed in the Catalog of Federal Domestic Assistance at *www.cfda.gov.* These statutory authorities and their program-specific regulations may supplement or create exceptions to the Government-wide regulations. The authorities and regulations for the vast majority of financial assistance programs do not address mitigation, but there are at least two exceptions. The statutory authority for the North American Wetlands Conservation Fund program (16 U.S.C. 4401 *et seq.*) prohibits the use of program funds for specific types of mitigation. Regulations implementing the National Coastal Wetlands Conservation Grant program (50 CFR part 84) include among the activities ineligible for funding the acquisition, restoration, enhancement, or management of lands to mitigate recent or pending habitat losses. To foster consistent application of financial assistance programs with respect to mitigation processes, the following provisions describe appropriate circumstances as well as prohibitions for use of financial assistance in developing compensatory mitigation.

A. What is federal financial assistance? Federal financial assistance is the transfer of cash or anything of value from a Federal agency to a non-Federal entity to carry out a public purpose authorized by a U.S. law. If

the Federal Government will be substantially involved in carrying out the project, the instrument for transfer must be a cooperative agreement. Otherwise, it must be a grant agreement. We use the term *award* interchangeably for a grant or cooperative agreement. This policy applies only to awards approved or administered by the Service in one of its 60 financial assistance programs. If the Service shares responsibility for approving or administering an award with another entity, the policy applies only to those decisions that the Service has the authority to make under the terms of the shared responsibility.

B. Where do most mitigation issues occur in financial assistance? Mitigation issues mostly occur in the match (cost share) proposed by applicants. Match is the share of project costs not paid by Federal funds, unless otherwise authorized by Federal statute. Most Service-approved or -administered financial-assistance programs require or encourage applicants to provide match.

C. Can the Federal or matching share in a financially assisted project be used to generate mitigation credits for activities authorized by Department of the Army (DA) permits?

1. Neither the Federal nor matching share in financially assisted aquatic-resource-restoration projects or aquatic-resource-conservation projects can be used to generate mitigation credits for DA-authorized activities except as authorized by 33 CFR 332.3(j)(2) and 40 CFR 230.93(j)(2)). These exceptional situations are any of the following:

a. The mitigation credits are solely the result of any match over and above the required minimum. This surplus match must supplement what will be accomplished by the Federal funds and the required-minimum match to maximize the overall ecological benefits of the restoration or conservation project.

b. The Federal funding for the award is specifically authorized for the purpose of mitigation.

c. The work funded by the financial-assistance award is subject to a DA permit that requires mitigation as a condition of the permit. An example is an award that funds a boat ramp that will adversely affect adjacent wetlands and the impact must be mitigated. The recipient may pay the cost of the mitigation with either the Federal funds or the non-Federal match.

2. Match cannot be used to generate mitigation credits under the exceptional situations described in section C(1)(a–c) if the financial-assistance program's statutory authority or program-specific regulations prohibit the use of match or program funds for compensatory mitigation.

D. Can the Service approve a proposal to use the proceeds from the purchase of credits in an in-lieu-fee program or a mitigation bank as match?

1. In-lieu-fee programs and mitigation banks are mechanisms authorized in 33 CFR part 332 and 40 CFR part 230 to provide mitigation for activities authorized by a DA permit. The Service must not approve a proposal to use proceeds from the purchase of credits in an in-lieu-fee program or mitigation bank as match unless both of the following apply:

a. The proceeds are over and above the required minimum match. This surplus match must supplement what will be accomplished by the Federal funds and the required-minimum match to maximize the overall ecological benefits of the project.

b. The statutory authority for the financial-assistance program and program-specific regulations (if any) do not prohibit the use of match or program funds for mitigation.

2. The reasons that the Service cannot approve a proposal to use proceeds from the purchase of credits in an in-lieu-fee program or mitigation bank as match except as described in section D(1)(a–b) are:

a. Proceeds from the purchase of credits are legally required compensation for resources or resource functions impacted elsewhere. The sponsor of the in-lieu-fee program or mitigation bank uses these proceeds for the restoration, establishment, enhancement, and/or preservation of the resources impacted. The purchase price of the credits is based on the full cost of providing the compensatory mitigation.

b. When credits are purchased from an in-lieu-fee program sponsor or a mitigation bank to compensate for impacts authorized by a DA permit, the responsibility for providing the compensatory mitigation transfers to the sponsor of the in-lieu-fee program or mitigation bank. The process is not complete until the sponsor provides the compensatory mitigation according to the terms of the in-lieu-fee program instrument or mitigation-banking instrument approved by the District Engineer of the U.S. Army Corps of Engineers.

E. Can the Federal share or matching share in a financially assisted project be used to satisfy a mitigation requirement of a permit or legal authority other than a DA permit?

The limitations on the use of mitigation in a Federal financially assisted project are generally the same regardless of the source of the mitigation requirement, but only the limitations regarding mitigation required by a DA permit are currently established in regulation. Limitations for a permit or authority other than a DA permit are established in this Service policy. They are:

1. Neither the Federal nor matching share in a financially assisted project can be used to satisfy Federal mitigation requirements except in any of the following situations:

a. The mitigation credits are solely the result of any match over and above the required minimum. This surplus match must supplement what will be accomplished by the Federal funds and the required minimum match to maximize the overall ecological benefits of the project.

b. The Federal funding for the award is specifically authorized for the purpose of mitigation.

c. The work funded by the Federal financial assistance award is subject to a permit or authority that requires mitigation as a condition of the permit. An example is an award that funds a boat ramp that will adversely affect adjacent wetlands and the impact must be mitigated. The recipient may pay the cost of the mitigation with either the Federal funds or the non-Federal match.

2. Match cannot be used to satisfy Federal mitigation requirements under the exceptional situations described in section E(1)(a–c) if the financial-assistance program's statutory authority or program-specific regulations prohibit the use of match or program funds for mitigation.

3. If any regulations govern the specific type of mitigation, and if these regulations address the role of mitigation in a Federal financially assisted project, the regulations will prevail in any conflict between the regulations and this section of Appendix C.

F. Can the Service approve a proposal to use revenue from a Natural Resource Damage Assessment and Restoration (NRDAR) Fund settlement as match in a financial assistance award?

1. The Service can approve such a proposal as long as the financial assistance program does not prohibit the use of match or program funds for compensatory mitigation. In certain cases, this revenue qualifies as match because:

a. Federal and non-Federal entities jointly recover the fees, fines, and/or penalties and deposit the fees, fines, and/or penalties as joint and indivisible recoveries into a fiduciary fund for this purpose.

b. The governing body of the NRDAR Fund may include Federal and non-Federal trustees, who must unanimously approve the transfer to a non-Federal trustee for use as non-Federal match.

c. The project is consistent with a negotiated settlement agreement and will carry out the provisions of the Comprehensive Environmental Response Compensation and Liability Act, as amended, Federal Water Pollution Control Act of 1972, and the Oil Pollution Act of 1990 for damage assessment activities.

d. The use of the funds by the non-Federal trustee is subject to binding controls.

G. Can the Service approve financial assistance to satisfy mitigation requirements of State, tribal, or local governments?

1. The Service can approve or administer funding for a proposed financially assisted project that satisfies a compensatory mitigation requirement of a State, tribal, or local government, or has match that originated from such a requirement.

2. Satisfying this mitigation requirement with Federal financial assistance must not be contrary to any law, regulation, or policy of the State, tribal, or local government as applicable.

H. Can a mitigation proposal be located on land acquired under a Service financial-assistance award?

1. A mitigation proposal can be located on land acquired under a Service approved or administered financial-assistance award only if:

a. The land will continue to be used for its authorized purpose as long as it is needed for that purpose.

b. The mitigation proposal will provide environmental benefits over and above the terms of the financial-assistance award(s) that acquired, restored, or enhanced the property.

2. Service staff must be involved in the decision to locate mitigation on real property acquired under a Service-approved or administered financial assistance award for one or both of the following reasons:

a. The Service has a responsibility to ensure that real property acquired under one of its financial assistance awards is used for its authorized purpose as long as it is needed for that purpose.

b. If the proposed legal arrangements or the site-protection instrument to use the land for mitigation would encumber the title, the recipient of the award that funded the acquisition of the real property must obtain the Service's approval. If the proposed legal arrangements would dispose of any real-property rights, the recipient must request disposition instructions from the Service.

Request for Information

We intend that a final policy will consider information and recommendations from all interested parties. We, therefore, invite comments, information, and recommendations from governmental agencies, Indian Tribes, the scientific community, industry groups, environmental interest groups, and any other interested parties. All comments and materials received by the date listed above in DATES will be considered prior to the approval of a final policy.

In addition to more general comments and information, we ask that you comment on the following specific aspects of the policy:

(1) Principles established by the policy in section 4, including the Service's mitigation planning goal of a net conservation gain, or at a minimum, no net loss, *i.e.,* maintaining the current status of affected resources.

(2) Integration of mitigation planning into a broader ecological context with applicable landscape-level conservation planning, by steering mitigation efforts in a manner that will best contribute to achieving conservation objectives.

(3) The integration of all applicable authorities that allow the Service to recommend or require mitigation within a single mitigation policy.

If you submit information via *http://www.regulations.gov,* your entire submission—including any personal identifying information—will be posted on the Web site. If your submission is made via a hardcopy that includes personal identifying information, you may request at the top of your document that we withhold this information from public review. However, we cannot guarantee that we will be able to do so. We will post all hardcopy submissions on *http://www.regulations.gov.*

National Environmental Policy Act (NEPA)

We have analyzed the proposed policy in accordance with the criteria of the National Environmental Policy Act (NEPA) (42 U.S.C. 4332(c)), the Council on Environmental Quality's Regulations for Implementing the Procedural Provisions of NEPA (40 CFR parts 1500–1508), and the Department of the Interior's NEPA procedures (516 DM 2 and 8; 43 CFR part 46). We have determined that the proposed policy includes substantive revisions to the 1981 Mitigation Policy that are not purely administrative in nature and cannot be categorically excluded from NEPA documentation requirements consistent with 40 CFR 1508.4 and 43 CFR 46.210(i). In addition, this action may have the potential to trigger an extraordinary circumstance, as outlined in 43 CFR 46.215. Therefore, we announce our intent to prepare an environmental assessment (EA) pursuant to the National Environmental Policy Act (NEPA) of 1969, as amended. We request comments on the scope of the NEPA review, information regarding important environmental issues that should be addressed, the alternatives to be analyzed, and issues that should be addressed at the programmatic stage in order to inform the site-specific stage. This notice provides an opportunity for input from other Federal and State agencies, local government, Native American Tribes, nongovernmental organizations, the public, and other interested parties.

Authors

The primary authors of the draft policy are the following staff members of the U.S. Fish and Wildlife Service: Karen Cathey of the Southwest Regional Office; Deborah Mead and Jason Miller (team leader) of the Ecological Services Program, Headquarters Office; Doreen Stadtlander of the Carlsbad Fish and Wildlife Office; Diana Whittington of the Migratory Birds Program, Headquarters Office; Jerry Ziewitz of the Southeast Regional Office; and other Headquarters, Regional, and field contributors. Primary support for policy development was provided by Cheryl Amrani of the Ecological Services Program, Headquarters Office.

Authority

The multiple authorities for this action include the: Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*); Fish and Wildlife Coordination Act, as amended, (16 U.S.C 661–667(e)); National Environmental Policy Act (42 U.S.C. 4371 *et seq.*); and others identified in section 2 and Appendix A of this policy.

James W. Kurth,

Acting Director, U.S. Fish and Wildlife Service.

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Federal Register

Vol. 81, No. 45

Tuesday, March 8, 2016

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Federal Register/Code of Federal Regulations

General Information, indexes and other finding aids — **202–741–6000**

Laws — **741–6000**

Presidential Documents

Executive orders and proclamations — **741–6000**

The United States Government Manual — **741–6000**

Other Services

Electronic and on-line services (voice) — **741–6020**

Privacy Act Compilation — **741–6064**

Public Laws Update Service (numbers, dates, etc.) — **741–6043**

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FEDERAL REGISTER PAGES AND DATE, MARCH

10433–10754 1
10755–11090 2
11091–11406 3
11407–11658 4
11659–12000 7
12001–12404 8

CFR PARTS AFFECTED DURING MARCH

At the end of each month the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

3 CFR

Proclamations:
9399 11091
9400 11093
9401 11095
9402 11097
9403 11653

Executive Orders:
13720 11089

Administrative Orders:
Memorandums:
Memorandum of March 1, 2016 11997
Notices:
Notice of March 2, 2016 11655
Notice of March 2, 2016 11657
Notice of March 3, 2016 11999

5 CFR

Proposed Rules:
870 12032

7 CFR

25 11000
65 10755
246 10433
905 10451
1703 11000
1709 11000
1710 11000
1717 11000
1720 11000
1721 11000
1724 11000
1726 11000
1737 11000
1738 11000
1739 11000
1740 11000
1753 11000
1774 11000
1775 11000
1779 ..... 10456, 11000
1780 ..... 10456, 11000
1781 11000
1782 11000
1784 11000
1794 11000
1924 11000
1940 11000
1942 ..... 10456, 11000
1944 11000
1948 11000
1951 11000
1955 11000
1962 11000
1970 11000
1980 11000
3550 11000
3555 11000
3560 11000
3565 11000
3570 ..... 10456, 11000
3575 ..... 10456, 11000
4274 11000
4279 ..... 10456, 11000
4280 ..... 10456, 11000
4284 11000
4287 11000
4288 11000
4290 11000

Proposed Rules:
800 10530
989 11678
1214 10530

8 CFR

Proposed Rules:
212 12032

10 CFR

Proposed Rules:
50 ..... 10780, 11681
52 11681
54 11681
100 11681
429 11686
430 11454
900 11686

12 CFR

1026 11099

Proposed Rules:
380 10798

14 CFR

25 10761
39 ..... 10457, 10460, 10465, 10468, 11407, 11409
71 ..... 11102, 11103, 11413, 11414, 12001, 12002
95 11659
252 11415

Proposed Rules:
39 ..... 10533, 10535, 10537, 10540, 10544, 10545, 10549, 11132, 11134, 11465, 11467, 11469, 11471, 11473, 11475, 11687, 11690, 12039, 12041, 12044, 12047
71 ..... 10551, 11136, 11139, 11692, 11694, 11695

15 CFR

701 10472
744 12004

16 CFR

Proposed Rules:
23 11697

17 CFR

Proposed Rules:
302.....10798

18 CFR

11.....10475, 12006

21 CFR

14.....11663
558.....11664
801.....11428
830.....11428
1308.....11429
Proposed Rules:
820.....11477
864.....10553
878.....11140, 11151
1308.....11479

22 CFR

Proposed Rules:
41.....12050

24 CFR

5.....12354
880.....12354
884.....12354
886.....12354
891.....12354
903.....12354
960.....12354
966.....12354
982.....12354
983.....12354
990.....12354
Proposed Rules:
266.....12051

25 CFR

20.....10475
151.....10477

26 CFR

1.....11104, 11431
301.....10479
Proposed Rules:
1.....11160, 11486
301.....11486

27 CFR

9.....11110, 11103

29 CFR

1910.....10490

31 CFR

605.....11432
Proposed Rules:
1010.....11496

32 CFR

104.....10491
199.....11665
706.....11116
Proposed Rules:
89.....11698

33 CFR

117 .....11118, 11434, 11668, 12007
165 .....10498, 10499, 10501, 10762, 11435, 11437
Proposed Rules:
100.....10557
165 .....10820, 11161, 11706

34 CFR

Proposed Rules:
300.....10968

36 CFR

1275.....12007

38 CFR

17.....10764
38.....10765
70.....10504

39 CFR

Proposed Rules:
551.....11164

40 CFR

52 .....11120, 11438, 11445, 11668, 11671, 11673
75.....10508
180 .....10771, 10776, 11121, 12011, 12015
Proposed Rules:
52 .....10559, 11497, 11711, 11716, 11717, 11726, 11727
81.....10563
85.....10822
86.....10822
1036.....10822
1037.....10822
1065.....10822
1066.....10822
1068.....10822

42 CFR

435.....11447
495.....11447
510.....11449
Proposed Rules:
405.....10720, 12024
410.....12024
411.....12024
414.....12024
424.....10720
425.....12024
455.....10720
457.....10720
495.....12024

43 CFR

2.....11124

45 CFR

144.....12204
147.....12204
153.....12204
154.....12204
155.....12204
156.....12204
158.....12204
Proposed Rules:
170.....11056

46 CFR

401.....11908
403.....11908
404.....11908
501.....10508
502.....10508

47 CFR

90.....10519
Proposed Rules:
15.....11166
63.....11500
64.....12062
74.....11166

48 CFR

Ch. I.....11988, 11993
1.....11988
4.....11988, 11992
9.....11988
22.....11988, 11992
25.....11992
36.....11992
52.....11988, 11992
1812.....10519
1819.....10519
1852.....10519

49 CFR

578.....10520
1540.....11364
Proposed Rules:
222.....11734
350.....12062
365.....12062
380.....11944
383.....11944
384.....11944
385.....12062
386.....12062
387.....12062
395.....12062
523.....10822
534.....10822
535.....10822

50 CFR

622.....11451
648.....12030
679.....11452
Proposed Rules:
622.....11166, 11502
648.....11168

LIST OF PUBLIC LAWS

Note: No public bills which have become law were received by the Office of the Federal Register for inclusion in today's **List of Public Laws**.

Last List March 2, 2016

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